

**Mainstreaming of Deaf Education in the Republic of
Ireland:
Language, Power, Resistance.**



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Summary

This thesis examines the mainstreaming of primary level deaf education in the Republic of Ireland. Following legislation in 1998 and again in 2004, parents of deaf and hard-of-hearing (D/HH) children are now facilitated in sending their child to the local school. As a result, there has been a dramatic increase in the numbers of D/HH in those settings and a subsequent decline in enrolment in schools for the deaf. No examination has been conducted, however, into the impact of mainstreaming on the situation in Ireland, in spite of serious concerns raised internationally about the inappropriate nature of mainstreaming for this cohort.

As a result, this thesis explores the changing geographies of deaf education in the Republic of Ireland. Drawing on interviews with parents, teachers, and D/HH children, it unpacks the policy, practice, and ideological foundations of mainstreaming in the Irish system. It is particularly concerned with the power relations at play in the system. Using theories on power by Michel Foucault and John Allen, I analyse the changing geographies of power and resistance at play in mainstreaming of deaf education. Historically, the field of deaf education has been an ideological battleground between medical and social models of d/Deafness. Changes in educational practice have typically seen a shift in the dominance of one model over the other. With the mainstream movement, the changing geographies of deaf education and the subsequent spatial dispersal of D/HH children from their peers has provided an opportunity for the mass 'normalisation' of this cohort through assimilation with hearing children. As a result, it threatens a social model of Deafness by hitting at the source of traditional resistance against medicalization of D/HH bodies: the use of Sign Language and the collective resistance facilitated by congregation of D/HH children at residential schools.

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Go raibh míle maith agaibh as an tacaíocht ar fad.

In memory of my grandmother
Bridget Mathews 1921-2009

1 Introduction

Some children do not hear. This can be for a number of reasons: there can be a variation on a chromosome carried by both their parents, there may be a mechanical obstruction in their middle ear, their auditory nerve may not function, there may have been trauma experienced at birth, they have been exposed to medication which causes harm to their aural faculties, or there could have been a viral or bacterial infection which left them with the inability to hear. As a result, these children will be marked out as different from their peers who can hear. Across different times and places, they have been known as deaf, deaf and dumb, mute, hearing-impaired, hard of hearing, or Deaf, but the most noticeable aspect of their difference from others has always been the difficulty they experience in communicating with their hearing peers, in acquiring language and subsequently, in learning.

As a result, over the last couple of centuries there has been a growing preoccupation with the 'best' means of eradicating the complications of deafness, and improving the educational achievement of these children. For a long time, the main approach was to adjust the medium of teaching, using a visual means of communication which was accessible - Sign Language. This represented a philosophy of education known as manualism. However, over time this ideology was challenged, and the burden of accommodation shifted to the child. The onus was placed on them to learn how to communicate and be educated through spoken language and listening - oralism. This was often accompanied by a staunch opposition to the use of Sign Language, viewed as a barrier to the acquisition of speech. While the debate between manualism and oralism may seem a linguistic or pedagogical one, it goes far beyond the reaches of language and indeed education to incorporate the social, the economic, and the political.

The manual/oral debate in deaf education has gone on almost since the field was established over 200 years ago, and even before then when a mere handful of

teachers across Europe¹ debated methodology. That debate has almost always centred on the use of Sign Language. As Baynton states: “the question was not, for [teachers of the deaf] or for most deaf people, whether oral communication should be taught. The fight was over sign language” (1996: 14). These debates reflect the contrasting desires for deaf and hard-of-hearing (D/HH) children to be normalised, integrated and assimilated within mainstream society where they can live and work amongst the hearing, versus being adopted by Deaf Culture through the use of Sign Language, where they can live alongside, but perhaps not truly within hearing society. As such, the debate has deep ideological roots based around contrasting models of what it means to be d/Deaf.

On the one hand, the medical model of deafness views hearing impairment as a pathological condition, caused by neurological or structural anomalies in either the ear or the auditory centre in the brain. Since for the medical model, deafness is equated with an inability to hear, overcoming deafness is involved with rehabilitating the hearing organs. Often this comes in the form of amplification (using hearing-aids) or surgery (cochlear implantation). This rehabilitation is accompanied by intensive therapy to assist the development of listening and speaking skills. As such, the medical model is aligned with an oralist philosophy.

On the other hand, over the last number of decades, recognition of the fact that Deaf people comprise a Deaf Community which shares a common language, Sign Language, with its own grammar and syntax (Stokoe, W., 1960), cultural norms and values, and history (Bienvenu, M., 1989; Groce, N.E., 1985; Lane, H., 1989; Lane, H. et al., 1996; Mow, S., 2001; Sacks, O., 1989; van Cleve, J.V. and Crouch, B.A., 1989; Woll, B. and Ladd, P., 2005) has highlighted the need for a socio-cultural perspective on Deafness, breaking away from the traditional medical view of hearing impairment. This rise of the socio-cultural model of Deafness, sometimes known as ‘Big-D Deaf’ is signified by the capitalisation of the word Deaf, indicating membership to a cultural and linguistic minority group, as opposed

¹ While it is likely that these debates were conducted beyond Europe, documented literature further afield is scarce. We know that deaf education in the US was established by an American clergyman who travelled to France to learn their methods. Similarly the Australian system was established by educators from Britain and Ireland.

to lowercase deaf which signifies an audiological deficiency. Although those identifying with the socio-cultural model of Deafness do not identify as disabled (Lane, H., 2002), the progress made in establishing a socio-cultural model must be situated within a generalised shift away from viewing disabilities as inherently personal obstacles towards one which examines the role of the physical, social, economic, or political environment in creating disability (Oliver, M., 1990).

Until relatively recently, the swing of dominance of one model over the other was played out in schools for the deaf, with particular schools favouring one method over the other with shifts occurring in response to varying social conditions. One consistent feature of this system, however, was that D/HH children had the opportunity to interact with large numbers of their D/HH peers, supporting the development of the Deaf Community. This fostered the growth of Sign Language, often regardless of the philosophy of the particular school². In adulthood, this community lobbied for their rights and the rights of D/HH children. In the second half of the 20th century however, this situation changed with the arrival of what became known as ‘mainstream’ education. At the time, the incorporation of selected D/HH children relied largely on the good will of teachers in local schools, and the success of individual children in acquiring speech. The majority of those in mainstream shared several characteristics: they were often deafened in childhood but after they had experienced some exposure to spoken language creating a cognitive and linguistic foundation for their later acquisition of oral skills; many had hearing losses of a severe level or below with few exhibiting profound losses; they responded well to amplification through hearing aids; and often they had middle-classed parents who could invest significant time and/or money into speech training classes. Those children who remained (profoundly, pre-lingually deaf children who did not respond to hearing aids) would be candidates for schools for the deaf and for Sign Language. Thus, it remained the case that there were identifiable candidates for one system or the other.

² There is evidence that even those children enrolled in oral schools devised their own forms of Sign Language to communicate with each other.

However, in the 1970s, pioneered by the US and followed shortly by the UK, a new philosophy would emerge whereby *all* D/HH children were deemed potential candidates for mainstream schools with only the very few remaining children relegated to schools for the deaf. This philosophy was supported by a number of legislative moves beginning with Public Law 94-142 in the United States in 1975. In Ireland, this move to mainstreaming would happen considerably later, with the *Education Act* of 1998 and the *Education for Persons with Special Educational Needs Act* (EPSEN) of 2004. The 1998 *Education Act* revolutionised special education in Ireland because, for the first time, legislation gave disabled children and their parents the legal right to obtain an education in their local community, and allocated funding and services to schools to teach children with special educational needs (Kitchin, R. and Mulcahy, F., 1999: 3). Again in 2004 the EPSEN Act stated that “[t]he provision of education to a child with special educational needs shall take place alongside the provision of education to children who do not have such needs”(Government of Ireland, 2004). This brought a radical shift in the demographic profile of deaf education placements.

It is now estimated that 90-95% of D/HH children are educated in mainstream settings (Crean, 1997). This is a complete reversal from 30 years ago, when over 90% were educated in schools for the deaf. As a result, there has been a significant change in the geographies of deaf education. Once centrally organised in schools for the deaf, D/HH children are now spatially dispersed from each other. This change has come with a great deal of concern from some professionals and the Deaf Community that mainstreaming may not be suitable for many of those who are currently placed there. Particular concerns are raised over educational and social isolation, the lack of appropriate services, the lack of training among staff in mainstream settings, and the lack of early intervention in Ireland aggravating the already complex terrain of hearing loss in infants. In spite of this concern, and the fact that it has been over 10 years since that initial legislation was passed, there has, to date, been no extensive research on the provision of education to D/HH students in mainstream. In light of this lack of research, this project aimed to examine the

policy and practice of mainstreaming deaf education in Ireland, with particular concern given to the ideology supporting mainstreaming.

Aims and Objectives

This research had a number of aims and objectives in relation to empirical, methodological and theoretical contributions to the discipline of geography as well as deaf education and Deaf studies. Empirically, since little research has been done in deaf education in Ireland, this research aimed to contribute to knowledge of that system on a national level by critically examining mainstreaming policy and practice and its effect on deaf education and the Deaf Community. Since a general overview of the situation was required, this research did not set out to focus on one specific aspect of mainstreaming. It did not concentrate on the social or academic aspects, nor did it limit itself to issues of access. Rather it used an open narrative interview approach to explore the journey of parents, children and teachers from the point of identification through early schooling to establish broad themes as they related to the mainstream experience. In accomplishing this aim it had three significant objectives:

1. To establish the current policy regarding the mainstreaming of deaf education in Ireland through legislation analysis
2. To identify the current practice of mainstreaming of deaf education in Ireland, in particular
 - To document the process of identifying hearing loss through medical institutions, in particular measuring any delays between the first point of identification and the final 'measured' hearing loss.
 - To examine the provision of early intervention services, paying attention to the various discourses of d/Deafness supported by such services
 - To investigate decision making processes among parents both in terms of the language they used to communicate with their D/HH child and the school placements they considered
 - To identify how parents accessed educational resources, in particular barriers or delays in the process

3. To contextualise both policy and practice of mainstreaming in the larger frame of literature regarding both the history of deaf education and contemporary international best practice.

In light of this third objective, the research was particularly committed to examining the ideological foundations of mainstreaming as articulated by the reasons parents chose that placement option, and the type of philosophy (manual/oral/other) supporting deaf education in that setting. This concentration on ideological foundations aimed to add to the existing knowledge on deaf education internationally which has traditionally been empirical and quantitative in nature, rarely engaging with theoretical discussion. In doing so, it situates the research findings within a larger framework of the history of deaf education, international practice, and the philosophy of 'inclusion'.

In terms of methodology, this research aimed to explore the use of transformative-emancipatory research epistemology, in particular the possibility of a Freirean approach to participatory research. In particular, it highlights the difficulties of conducting research within communities of which you are not a member, as well as issues accessing data where gatekeepers are present. It explicitly tackles issues of empowering research and the responsibilities of researchers within an emancipatory research framework.

The research aimed also to contribute to theory, in particular on geographies of power. The overall theoretical framework for the thesis derives from the work of Michel Foucault (1965, 1976, 1977a, 1977b, 1977c, 1978, 1982, 2002) as well as literatures on geographies of power (Allen, J., 2003; Rose, M., 2002; Sharp, J.P. et al., 2000a). This framework is used as a lens for the current system of deaf education to highlight how the changing geographies of that system, brought about by mainstreaming, have had a direct impact on power relations as they are played out between parents, professionals, and the Deaf Community. The struggle between medical and social models therefore, has taken on a new spatial dimension in the wake of mainstreaming, whereby traditional paths of resistance used by the Deaf Community (facilitated through congregation in schools for the deaf) come under

threat in an 'inclusive' environment. In analysing this struggle, I respond to Allen's (2003) call to pay attention to the particular modes of power as well as their spatial and temporal constitution.

Inspired by Foucault's genealogy works, I also acknowledge that both contemporary *and* historical contextual factors as they relate to the construction of 'truth' and power must be made explicit. In spite of the fact that mainstreaming is a recent occurrence in the Irish situation, providing contemporary context alone is not enough. As a result, chapter 5 deals with the history of deaf education both internationally and in Ireland, and outlines the origins of d/Deafness as both a social and medical construct, and a history of the lived experience of D/HH people through those education systems. A Foucauldian analysis on the history of deaf education is conducted, concentrating on how a hegemonic medical model of deafness was established at the beginning of the 19th century. As such, a historicist approach was used, framing recent policy moves in a larger historical development of the pathologising and normalising of D/HH children.

Structure of the Thesis

The first section of this thesis (up to and including chapter 5) provides the background and context for the research. Chapter 2 reviews the literature on mainstreaming of deaf education and assesses the development and rationale of mainstreaming policy, concentrating on current provision for D/HH students in Ireland. Beyond mere description however, it was particularly concerned with examining mainstreaming as an extension of an institutionalised process of normalisation, driven by a hegemonic medical model of deafness. Chapter 3 outlines the methodological approach used in the research while chapter 4 provides the theoretical backdrop for the discussion chapters. The final chapter of this section (on history) provides a detailed examination on the ideological foundations of deaf education and in particular the evolution of oralism and a medical model of deafness – I argue here how a hegemonic medical model of deafness was established in the 19th century.

The second section (chapters 6, 7 and 8) provides results from the empirical research carried out. Chapter 6 provides a quantitative and qualitative description of the system of deaf education as it currently stands in the Republic of Ireland. It deals with early identification and intervention services, schooling options available, and services provided within school settings. It also outlines staff and student demographics collected from an annual survey conducted as part of this PhD research. This chapter (descriptive and not analytical in nature) acts as a springboard from which the discussion chapters (7 and 8) progress. Chapters 7 and 8, both theoretically and empirically informed examine the reproduction and contestation of a hegemonic medical model of deafness in the current system.

Chapter 7 builds on the historical analysis provided in chapter 5 by addressing how a hegemonic medical model of deafness is reproduced in the current system. It examines the reproduction of this hegemony by examining the various modes of power at play. Using Allen's (2003) *Lost Geographies of Power* as an example of the nuances and complexities found in the exercise of power, it examines the current system as a product of the manipulation, inducement, coercion and subjectification of parents, the proliferation of medical authority, the domination of teachers, and the subjectification of D/HH children. In line with Allen (2003), it addresses the spatiality of power, especially how this is played out in the mainstream system where deinstitutionalisation and the subsequent shift in the geographies of governance would suggest a change in how power operates.

Chapter 8 acknowledges that any act of power can be met with an act of resistance, and indeed that there is power *in* resistance. It outlines both traditional and contemporary forms of resistance against a hegemonic medical model of deafness. It analyses the changing geographies of resistance in the wake of mainstreaming, and how the decline in residential schools has had an impact on how resistance is practised. Specifically, while resistance was traditionally in the hands of the Deaf Community, passing from one generation of D/HH children to the next in the residential school system, resistance must now emerge from the actions of hearing parents on behalf of their D/HH children. The fracturing of the traditional forms of resistance available to the Deaf Community is examined as a cause of deep

unrest within that community regarding the mainstreaming movement. Chapter 9 provides a conclusion and summary of the thesis as a whole.

Terminology

It is important to clarify the use of particular terminology through this thesis. Terms used to refer to D/HH people are not neutral, but rather are laden with political meaning. In recent years, there has been a distinction between deaf (spelled with a lower case 'd') and Deaf (upper case 'D') to clarify between medical and social discourses of d/Deafness respectively. As such, the term 'deaf' refers to an audiological deficiency while 'Deaf' refers to membership of a minority community, the Deaf Community, and use of Sign Language for communication.

While the terms 'hearing impairment' or 'hearing loss' are still commonly used by many hearing people, including a number of parents involved in this research, it is seen as offensive by the Deaf Community since it uses a deficiency model. This term is only used in this thesis when it appears in direct quotations from interviews or where used specifically in relation to a medical model deafness. In spite of the fact that the vast majority of the children involved in this research were profoundly deaf, the term 'deaf or hard-of-hearing' (D/HH) is used throughout the thesis to give due weight to the fact that there is a continuum of identification along which these children are placed by others and/or themselves. This term also respects the fact that 'hard of hearing' as an identity is distinct from d/Deaf (Israelite, N. et al., 2002). The acronym D/HH, using all capital letters, allows for the fact that this identification may be cultural, but its use does not indicate that *all* participants are culturally Deaf. When it is particularly important to distinguish between the medical and social models of d/Deafness, individual terms with the appropriate capitalisation of letters will be used.

The term Sign Language is capitalised to highlight that Sign Languages are languages in their own right, with their own linguistic structure, and are not simply visual representations of spoken language. Signed English, on the other hand, refers to a manual system which places signs (often borrowed from Sign Language) in English word order. Unlike Sign Language, it does not have its own unique syntax

or grammar and as such is spelled with a lower case 'signed' and upper case 'English'. When necessary, the Sign Language of a given nationality will be specified, such as Irish Sign Language, British Sign Language, American Sign Language. These are all distinct from each other; Sign Language is not universal.

There is also a need for clarification around the terms 'mainstreaming', 'integration', and 'inclusion'. For the purpose of this thesis, mainstreaming refers to the placement of D/HH students in regular school classrooms. Two types of mainstreaming are discussed in this thesis: individual or full mainstreaming and group mainstreaming. Individual or full mainstreaming refers to those students who are the only D/HH student, or one of very few D/HH students within their school. Oliva (2004) refers to these students as 'solitaires'. Group mainstreaming takes place when there are a number of D/HH students grouped together in a unit within a mainstream school. These units are sometimes referred to as facilities for D/HH children, special classes, or partially hearing units. In this thesis, they will be referred to simply as units. Within units, there will be varying degrees of participation among these students within mainstream classes, ranging from those who receive resource support within the unit and are in the mainstream classroom for the rest of their academic subjects, to those students who are only integrated with hearing peers for extracurricular activities. Schools catering specifically for D/HH children are referred to as 'schools for the deaf'. While the term 'the deaf' is viewed in negative terms because of its assumption of homogeneity among that cohort, the term 'school for the deaf' is in common use by parents, service providers, and the Deaf Community. Some professionals and parents refer to these schools as 'special schools', a term disliked greatly by the Deaf Community. As such, the term does not feature in this research.

For the purpose of this thesis, mainstreaming and integration are synonymous. One of the distinguishing features between mainstreaming/integration and inclusion is the provision of specialist pull-out services in the former, for example resource teaching. While mainstreaming/integration is an educational practice, inclusion, on the other hand, is more of a philosophical and ideological process. In other words, inclusion, rather than being an attitude, is a place (Powers,

S., 1996). Within inclusive education environments, "schools attempt to provide for the personal, social, and learning needs of *all* their students" (Power, D. and Hyde, M., 2002: 302). As a result, any specialist services required by the child being included are provided within the general classroom and not outside it as is the case in mainstreaming (Jackson Croyle, C., 2003). Subsequently, students can be integrated or mainstreamed without being included. While the rhetoric of inclusion is common in Ireland, in practice the 'pull-out' system for resource provision is widespread to the point of being ubiquitous.

Conclusion

There are those³ who say that the battle between manualism and oralism is over, and that the new educational ideology of individualised plans means that each D/HH child is assessed and the method most appropriate to them is chosen. However, there are a number of issues which complicate this situation. First of all, the overwhelming majority of D/HH children are born to hearing parents, who are unlikely to have any previous experience with the Deaf Community. Furthermore, the occupations dealing with D/HH children (medical and educational) are overwhelmingly populated by hearing professionals. This dominance of hearing individuals has tended to prioritise the medical model. It is clear that this medical model, in Padden and Humphries' terms (1988), has a different 'centre' from that of the Deaf Community. As a result, D/HH children are held to standards of normalisation as designed by medical and educational professionals as opposed to standards set from a Deaf 'centre'. As Davis and Watson (2001) observe, regarding children with disabilities generally:

The child is forced to fit into already existing educational and social processes and practices, which afford little space for the investigation or understanding of difference. This process is not so surprising when considered in the context that most research with disabled children has been preoccupied with differentiating children on the basis of their impairments, 'measuring children's bodies and minds against physical and cognitive norms' (Priestley, 1998). That is, it is not surprising that adults in schools pathologise disabled children when their lives have also been homogenised in both social and medical research.

³ Personal communication, visiting teachers and other educational professionals.

In such a system, the practice of mainstreaming would force D/HH children to 'fit into already existing processes' which use speech and hearing for communication. Therefore, speech is viewed as a necessity for a D/HH child and the mainstream school is the optimum environment to foster that spoken language development.

This thesis examines how and why D/HH children are mainstreamed. In the absence of research on this topic in Ireland, it casts a critical eye on a system which has gone virtually unchallenged⁴ for many decades to the point that it has become almost hegemonic in nature. The research was conducted and is represented here in a manner mindful of the history, culture and values of the Deaf Community. In uncovering how the dominance of the medical model is achieved and reproduced in the current system, it hopes to provide opportunities for resisting the system since, as Allen observes "[b]efore we can embark upon alternative paths to action and social change, we need to be aware of what it is that we face and how power in its more provisional yet spatially nuanced guises exercises us" (2003: 196).

⁴ The Deaf Community and their advocates have challenged the system consistently, but such challenges have often made little ground within government. Lacking the impact of academic research, or the input of policymakers, it has been confined to conferences organised by the Deaf Community. This is not a criticism of the work of the Deaf Community, but rather an observation of the lack of heed given by policymakers to the calls of the Deaf Community for an examination of this system.

2 Deafness and Education

Research on Mainstreaming

During the 1990s, a growing awareness of geographies of people with disabilities emerged. This awareness was characterised by debates on the particular models of disability used within research (Gleeson, B., 1996; Golledge, R.G., 1993; Hall, E., 1999; Imrie, R., 1996). In spite of this emerging interest in people with disabilities, the geographies of deaf people (Butler, R. et al., 2001), as well as geographies of children with disabilities (Holt, L., 2003) was largely overlooked at this time. As a result, geographical debate on the experience of inclusion and exclusion facing these children in mainstream settings has been sparse (Holt, L., 2003). This is regrettable since mainstreaming is first and foremost a spatial process, rationalised by the concept that children with and without disabilities educated in physical proximity will grow an increased tolerance and understanding of each other and counteract the stigma fostered when children with disabilities are segregated for education. There has, however, been a flurry of debate around the topic within the field of special education which can provide a background to the rationale and concerns surrounding the mainstreaming project.

While special education research in Ireland addresses the issue of mainstreaming, the field of deaf education has been under-researched, no doubt aggravated by the closure of the teacher training programme for teachers of the deaf which had been in operation in University College Dublin until the late 1990s. In spite of this programme running through the 1980s and 1990s, the last systematic examinations of deaf education in Ireland was the 1972 report by the Committee on the Education of the Hearing-Impaired, the recommendations of which have greatly shaped the current system. While research exists in Ireland into the history of deaf education (Griffey, 1994; Crean, 1997; Pollard, 2006), as well as a number of reports into education in schools for the deaf (O'Mahoney, E., 2009; Ryan, P., 2006; Swan, E., 1994), contemporary research on education as a whole is limited to commissioned reports (Conroy, P., 2006) including one extensive but unpublished work by Leeson (2007) on behalf of the National Council for Special Education. As

a result, there is a particular dearth of research into the mainstreaming phenomenon which only became active in legislation in 1998 (*Education Act*) and with more force in 2004 (*Education for Persons with Special Educational Needs Act*). There is, nonetheless some recent research available from the special education field in Ireland on the issue of mainstreaming in a national context.

Internationally, research on mainstreaming of deaf education is vast and varied, but is overwhelmingly quantitative in nature, frequently employing the use of psychometric, standardised educational testing and multiple regression analysis as a means of identifying significant factors in the academic and social success of D/HH students. However, significant problems and limitations have been identified in the use of standardised tests with D/HH children, in particular due to the reliance on English language (or other mother tongue) (Powers, S. et al., 1998). Some qualitative analysis has been conducted on mainstreaming also, including a number of significant longitudinal or in-depth ethnographic works (Gregory, S. et al., 1995; Komesaroff, L., 2008; Ramsey, C.L., 1997). Across the research, a great deal of conflicting evidence is presented showing that while such research may help in pointing to some important academic and social factors within the deaf education process, its greatest conclusion is that no one method will appropriately meet the needs of all D/HH children and that the academic and social success of D/HH children is dependent on a wide variety of multifaceted and interdependent factors.

The abundance of quantitative empirical research in deaf education has created problems in itself, in particular the fact that it promotes the continued pathologising of D/HH children (Lane, H., 1992). By taking the D/HH child (his/her impairments, successes, and failures) as the focus of research, attention has been drawn away from the environmental, cultural and social factors at play in mainstreaming. As such, analysis of the mainstreaming phenomenon through a theoretical lens employing a social model of disability/Deafness has rarely been conducted. In particular, the importance of language and the power inherently embedded within language policies in the field of deaf education warrants further examination. This thesis is particularly concerned with mainstreaming as a function of power, discipline and normalisation and how this plays out through the use of

speech versus Sign Language in the general classroom. While language features as a frequent area of examination in the literature, the focus is often on the impact of language mode (signed versus oral usually) on social and academic success in inclusion programmes and less frequently an examination of language as an effect of power as well as a means through which power is exercised and resisted in the classroom. Work of this nature is more common to historical analyses on deaf education and there exists a large body of material on the manual/oral debate as it was played out historically.

The following literature review begins with the emergence of geographies of disabilities. It moves from geography to the field of special, and then deaf education to look more closely at the rationale behind and research conducted on mainstreaming. Looking specifically at deaf education, it will examine both the academic and social aspects of mainstreaming. It will also draw on that limited research within deaf education which prioritises questions of language policy, theoretical examinations of mainstreaming, with a critical eye on the process as a force of hearing authority, discipline and normalisation.

Geographies of Disability

Prior to the 1990s, studies on disability in geography were largely positivist and from a medical model perspective, often focusing on epidemiology and mapping the occurrence and spread of disease or disabilities (Park, D.C. et al., 1998). During the 1990s however, growing awareness through the activism of people with disabilities and the development of a social model of disability raised important issues about how geographical research should engage with people with disabilities. These issues came to the fore in particular through a series of discussions and responses to Golledge's call for a geography *of* and *for* the disabled (Golledge, R.G., 1993). This is discussed in the methodology chapter, but suffice to say here that the 'Golledge versus others' debate represented the dualism widespread in disability discussions at the time with the medical model on the one hand and the social model on the other. This binary opposition between social and medical perspectives was challenged within geography (Hall, E., 1999), reflecting on criticisms of the social model from

feminist literature and calling for a re-examination of the materiality of the body and the need for an embodied geography. This call for embodiment is not without caution however, as reintroducing biology may allow “claims of weakness and bodily determination” to return (Hall, E., 1999: 25). However, Hall insists that the body must return as a topic of true examination and points to Connell’s concept of ‘transcendence’ (how social practices *form* the biology of bodies) and Freud’s ‘imprints’ (the body as a system of open interaction between emotions, environment, physical manifestations, etc) as a means of merging materiality and social constructivism (Hall, E., 1999: 26).

This debate gave rise to the bio-sociological approach to disability whereby both the social effects of discrimination and inaccessible environments *and* the embodied reality of impairment are deemed as necessary areas of investigation (for more see Imrie, 2003). The bio-sociological approach is adopted in the thesis, highlighting that while much of the discrimination faced by D/HH people stems from an inaccessible environment, the embodied reality of hearing impairment has a significant effect on the development of D/HH children that must be taken into account when planning further education. As a result, an examination of mainstreaming must keep watch both of the physiological 'facts' of deafness as well as the discriminatory potential of an environment created by and for hearing people.

Skelton and Valentine (2003a) highlight that work on D/HH people has been absent from geography (although their research has come some way in addressing this lacuna) and that even within Deaf Studies, D/HH young people are frequently marginalised. Previous research from geography on d/Deafness, has focused largely on young D/HH people (aged 16 and over) and has highlighted transition to adulthood, issues of inclusion and exclusion at home, school, work and in the Deaf Community itself, identity formation and political participation as issues of key interest (Butler, R. et al., 2001; Skelton, T. and Valentine, G., 2002, 2003a, 2003b; Valentine, G. and Skelton, T., 2003, 2007). While this work has flagged the significance of communication methods used during the D/HH child's upbringing as well as the influence of the medical model in influencing these decisions, it reflects on young D/HH people's views retrospectively of this period. This thesis will

instead focus on how decisions are made regarding communication, the implications that they have in early childhood, and the issues of power and resistance inherent in the decision-making process.

History of Mainstreaming Rationale and Policy

While there is evidence of including D/HH children in public schools from as early as the nineteenth century in the US (Van Cleeve, J.V., 1993), it is from the 1970s that there has been a systematic move towards mainstreaming policy ending the segregation of children with disabilities from their peers in an educational context. This movement has its roots in other civil rights movements of the 1960s and 1970s which saw an increased focus on ideologies of equality, human rights, and individual diversity (Moores, D.F., 1992). Furthermore, it can be viewed as a backlash against a heightened awareness of institutional abuse of children with disabilities in residential care, and Moores suggests that "to a great extent, in the public's mind the line between institutionalisation and residential schools was blurred" (1992: 23).

Since then, there has been a flurry of both national and international legislation supporting the mainstreaming movement culminating internationally in the Salamanca Statement published in response to the UNESCO World Conference on Special Needs Equality and Quality in Spain in 1994 which recognises that children with special educational needs will achieve their "fullest educational progress and social integration" by being included in their local mainstream school (UNESCO, 1994). As a result of these policy measures, there has been a noticeable increase in the number of children with disabilities being educated in their local mainstream school and a simultaneous decrease in those attending specialised schools. Initially this move *integrated* children with disabilities, simply moving them into the same school location as their nondisabled peers but either educating them separately or continuing to remove them for specialised resource services. Following criticism however, *inclusion* has become the goal, with disabled children taking their place as full members of the mainstream classroom, receiving support within that classroom setting. Whether inclusion or integration is practised, this phenomenon has become so widespread that, as Holt observes "there is a growing

international hegemony, which identifies the mainstream school as *the* place to educate (most) disabled children" (2003: 120, original emphasis).

Aside from being grounded in the civil rights movement, this mainstreaming philosophy is frequently supported by various academic and social rationales, highlighting the benefits of educating children together (Van Cleeve, J.V., 1993). Academically, children in segregated special education were frequently disadvantaged by not accessing a balanced curriculum, and not having the guarantee of a nationally recognised qualification (Griffin, S. and Shevlin, M., 2007). Physical/sensory disabilities were often confused with intellectual disabilities leading to low expectations and overprotective attitudes towards these children, contributing to the notion that "their social and learning needs were significantly dissimilar to other children so that they required separate education away from their mainstream peers" (Griffin, S. and Shevlin, M., 2007: 2). Socially, the physical segregation of disabled and non-disabled children fuelled the stigmatization of disabled children leading to the common assumption that children with disabilities were "qualitatively different" from their nondisabled peers (Griffin, S. and Shevlin, M., 2007: 2). The lack of interaction between disabled and nondisabled people throughout their education fuelled the stigmatisation of disability as well as perpetuating the lack of understanding among nondisabled people towards their disabled peers. As a result, the interactions between people with and without disabilities are thought to be dominated by ignorance and fear (Wilton, R.D., 2003). Griffin and Shevlin (2007) refer to the National Disability Authority survey conducted in 2002 which echoes findings of a similar survey conducted in the 1980s by McConkey and McCormack showing a general lack of knowledge regarding disability in Ireland, with particular confusion between general learning disabilities and mental health difficulties. The move to mainstreaming or inclusion attempts to address the stigmatisation and has been inspired by the contact hypothesis (Allport 1954 cited in Hung, H.-L. and Paul, P.V., 2006: 59). This hypothesis proposes that increased contact "involving equal status, mutual goals, and active cooperation" between those from a stigmatised group (children with disabilities) and their unstigmatised peers would foster positive attitudes towards the former. Thus,

inclusive education aims to improve the social and academic outcomes for children with disabilities, minimising the stigma associated with disability, and enhancing the awareness of non-disabled children toward their disabled peers.

As a result of this rationalisation of inclusion, mainstreaming policies have been supported by legislation on both national and international levels. National legislation was pioneered in the United States in 1975 when President Ford passed Public Law 94-142 the *Education for All Handicapped Children Act* (later to become the *Individuals with Disabilities Education Act - IDEA*) which made two important propositions: that all children were entitled to a free and appropriate education (FAPE) and that that would be provided in the least restrictive environment (LRE). While not explicitly stated within the act itself, the LRE became widely interpreted in both court and classroom as the local mainstream school. The precedents for this piece of legislation included both the changing philosophy among educators which questioned the suitability of segregating children with disabilities, along with a number of landmark court cases (*Pennsylvania Association for Retarded Citizens v. Commonwealth of Pennsylvania* and *Mills v. Board of Education of the District of Columbia*) which identified the public school as the most suitable placement for children with disabilities (Moore, D.F., 1992).

Regarding deaf education, the rubella epidemic of 1963-1965 created a large population of D/HH students requiring education and is likely to have increased the pressure for public school placements for this cohort at this time (Ramsey, C.L., 1997). Initially, this legislation involved movement of D/HH students into the general education system, though not necessarily a general education classroom. In 1997, while almost half of the D/HH student population were in public schools, only 34% were integrated either part-time or full-time (Holden-Pitt and Diaz 1998 cited in Antia, S.D. et al., 2002: 214). As a result of this, the *Regular Education Initiative* moved the focus in the 1980s to inclusion, stressing that special education services should be provided within mainstream classrooms, thus calling for an end to a dual system of education (Antia, S.D. et al., 2002).

In Ireland, education was traditionally segregated with non-disabled children attending mainstream schools and their disabled peers attending so-called 'special'

schools. In the 1970s, this diversified somewhat with a growth in special classes within mainstream schools with varying degrees of supported integration for children with disabilities (Shevlin, M. et al., 2002). Mainstreaming legislation came into force in Ireland during the late 1990s, which was a period characterised in general by great educational analysis and change. Drudy and Kinsella (2009) point to four factors which contributed to this change: international conventions and agreements, outcomes of constitutional cases, the work of government appointed task forces, and legislative reform. International conventions have been particularly significant and Clancy (2005) points to the 1990 OECD *Review of National Policies for Education: Ireland* as the main catalyst for a flurry of educational debate. The criticisms of this review on the weak administration and policy making aspects of the Irish system were met with the number of government reports and publications on the status of education: the 1992 *Green Paper*, 1995 *White Paper*, 1999 *White Paper on Early Childhood Education*, the *White Paper on Adult Education* 2000, the 1993 *Report of the Special Education Review Committee* to name a few. This last report, the *Special Educational Review Committee* (SERC) Report was one of the main instigators for mainstreaming policy, along with the criticisms of the United Nations Committee on the Rights of the Child in relation to the Irish government's response to implementing the *United Nations Convention on the Rights of the Child* (UNCRC), which brought the issue of education for children with disabilities onto the agenda (Richardson, V., 2001). Further to this, the 1996 *Commission on the Status of People with Disabilities* argued for the legal recognition of rights for people with disabilities in the area of education (Drudy, S. and Kinsella, W., 2009). These criticisms combined with the papers published in education throughout this decade gave rise to the enactment of legislation, which until that point had been a scarce phenomenon in Irish education (Clancy, P., 2005: 83). This legislation included the 1997 *Universities Act*, the 1998 *Education Act*, the 1999 *Qualifications Act*, the 2002 *Education for Persons with Disabilities Act*, and the 2004 *Education for Persons of Special Educational Needs Act*. The 1998 Act and 2004 Act identify the mainstream school as the ideal educational environment for children with

disabilities⁵, and provide parents with the legal entitlement to pursue that placement for their child.

Clancy (2005) states that as well as the national measures, changes to national legislation must be contextualized vis-à-vis Ireland's relationship with Europe. The criticism of the implementation of the UNCRC mentioned above was coupled with what Clancy (2005) identified as two major concerns emerging from education policy across Europe both of which have had an impact on mainstreaming children with disabilities. The first is the relationship between education and the labour market. In relation to special education, the needs of the market economy and resulting demands that a greater number of people receive uniform education to enable them to move into employment meant that people with disabilities without ample training may be counted as a drain on, rather than a support to a national economy. As a result, training D/HH people within a mainstream situation could be viewed as a measure of preparing them for work in a hearing workplace and providing them with the skills necessary for that work: education, training in spoken English, and increased interaction with hearing peers.

The second concern is the potential that education affords to providing equity, social justice and improvement in the situation of the disadvantaged populations of Europe. Among the principles laid out in the 1995 *White Paper* there are a number which focus on social cohesion, with references to creating

tolerant, caring and politically aware members of society ... [with an] ...awareness of national and European heritage ... [and fostering] ... an understanding and critical appreciation of the values - moral, spiritual, religious, social and cultural - which have been distinctive in shaping Irish society and which have been traditionally accorded respect in society (Clancy, P., 2005: 82).

As a result, mainstreaming ideology often relies on discourses of equality and social cohesion. It is this latter concern which has drawn the most attention regarding mainstreaming of D/HH children. In their research with various stakeholders in inclusive education in Ireland, Drudy and Kinsella (2009) found that participants

⁵ Clauses exist should mainstream placement be detrimental to either the child with disabilities or their peers (see the EPSEN Act 2004 section 1 paragraph 2 for example).

viewed educational inclusion and social inclusion to be inextricably linked, a fact to which we will return later with regard to D/HH children in mainstream schools.

Overall, it can be seen that the mainstreaming movement, which has gathered ground since it was pioneered in the 1970s in the US, has its roots in a complex network of both national and international policy agendas. The result in the Irish context has been a rapid rise in the number of children with special educational needs attending mainstream schools (41% increase from 1998 to 2005) and a subsequent rise in the numbers of resource teachers and special needs assistants available to cater for those children (Drudy, S. and Kinsella, W., 2009). According to Bronfenbrenner's ecological theory (1979 cited in Hung, H.-L. and Paul, P.V., 2006: 69) changes at the macro level of the system, such as implementing inclusive policies and legislation, affects all other levels within the system. Subsequently, inclusive policy on a national and international level which fosters tolerance and full participation of children with disabilities should trickle down to the micro level impacting on schools and classrooms. However, this is not necessarily the case.

Shevlin, Kenny et al (2002: 160) argue from their research that in practice there is a lack of infrastructure to support inclusion and an absence of real challenge to the systemic barriers facing inclusion. Drudy and Kinsella (2009) point to the rapid change from 1998 onwards when highlighting that children with special educational needs may not be served by appropriately qualified staff. The lack of systemic change on a national level has been highlighted repeatedly and the overall situation is adequately summarised by Drudy and Kinsella who state:

While significant efforts have been made in most schools to cater for pupils with disabilities/special educational needs, there is no consistent model of integrated or inclusive practice evident across the majority of Irish schools, as practices tend to vary considerably from school to school. It does not appear that Irish schools in general have undergone the restructuring that is required to effectively meet the needs of the vast majority of pupils who are presenting with difficulties. The indications are, therefore, that the practices generally adopted to respond to the needs of pupils with disabilities/special educational needs are derived more from the integrationist rather than from the inclusionist perspective (Drudy, S. and Kinsella, W., 2009: 659).

As well as this national concern over the lack of systemic change, there has been a great deal of international concern over the appropriateness of the mainstream classroom for D/HH children. Such has been the level of concern, that the

Salamanca Statement, arguably the backbone of the international mainstreaming movement, argues that “owing to the particular needs of deaf and deaf/blind persons, their education may be more suitably provided in special schools or special classes and units in mainstream schools” (UNESCO, 1994: 18)

Deaf Children in Mainstream: Exclusion/Inclusion

The denial of linguistic and cultural differences between deaf and hearing children ignores the situation in which deaf children find themselves (Komesaroff, L., 2008: 120).

Since its inception, the mainstreaming of deaf education has been a cause of great inquiry and indeed much controversy (Antia, S.D. et al., 2002). This is particularly worrying considering the educational difficulties faced by D/HH children even when they are provided with specialist services. For example, research in Ireland examining the educational experiences of over 300 D/HH people over the age of 18 has shown that while D/HH people tend to stay in school beyond the age of 18, they are less likely than their hearing peers to complete the leaving certificate, less likely to go on to third level, and when they do, have high levels of dropout from third level (Conroy, P., 2006). While there are a number of complex factors at play surrounding the mainstreaming of D/HH children, the controversy over the issue is largely due, as Komesaroff highlights above, to the language, communication and cultural differences between D/HH children and their hearing peers, and the difficulty in bridging those differences in an environment where speaking and listening, that is the preferences of hearing children, are paramount.

As a result, mainstreaming of deaf education has often been seen as a 'special' case, leading to the recommendations of the Salamanca statement mentioned above. In order to understand the complexities involved in mainstreaming deaf education, it is important to understand first the principles of language acquisition and why, for D/HH children, acquiring spoken language is an obstacle. This obstacle is at the centre of the mainstreaming debate regarding D/HH children since in the overwhelming majority of cases mainstreaming requires that the child be able to communicate both expressively and receptively through the

medium of spoken English. While the following section goes into detail on the physiological impairment of hearing loss, and is thus not honouring a social model of Deafness, it is in line with the bio-sociological approach outlined above which gives weight to the importance of the physicality of deafness and its impact on child development, while at the same time acknowledging that discrimination is a social phenomenon.

Language Acquisition and Cognitive Development

Extensive research has gone into examining processes of first language acquisition and various theories have subsequently emerged. Each theory involves three components: the child, the language to be mastered, and the environment, but each theory differs in the emphasis placed on each component. In general there are three schools of thought: Behaviourism, Nativism (linguistic and cognitive) and Social Interactionism. Behaviourist theory stresses the importance of the environment in language acquisition and contends that language acquisition is not an innate or natural process, but rather one that originates entirely outside of the child. Skinner (1957) proposed that language acquisition is an operant conditioning. That is, children receive stimuli (language from the environment) and their response to this stimulation is either reinforced – encouraging it to continue, or punished – encouraging it to cease (in Martin, R., 2002). Children are passive in the process of language acquisition and all progress comes from outside of the child. Nativists, on the other hand, believe that children possess an innate ability to learn language. They are born with a natural ability which Linguistic Nativists, such as Chomsky (2002), believe is housed in a specific region in the brain called the language acquisition device (LAD). They believe that learning language is a specific task, not directly related with learning other cognitive activities. Cognitive Nativists feel that this innate ability is more a general cognitive ability and not restricted to language use only. Finally, Social Interactionists emphasise the importance of two-way dialogue or ‘social interaction’ in the acquisition process. Here, language acquisition is a unique task, but it is a taught and not innate process.

It is not within the remit of the current work to argue the merits or disadvantages of the theories above, but a number of areas of common ground emerge from all three which are of significance to this research. First of all, whether it is named stimulation, interaction, or input, language acquisition must contain some form of social exchange. It cannot be done in isolation of social interactions. In essence, as Easterbrooks & Baker highlight “[t]he major reason we communicate is to meet our needs in the context of other human beings...we have to have someone to communicate *with*” (2002: 40). Secondly, language acquisition is not modality specific. In other words, language acquisition occurs in the same way for Sign Language as it does for spoken language (Petitto, L.A., 2000). As a result, language acquisition occurs in D/HH children of D/HH parents (through Sign Language) at the same rate as it does with hearing children of hearing parents. Thirdly, unlike literacy development, language acquisition occurs 'naturally' as opposed to being taught.

For this development however, there are a number of specific pre-requisites: the cognitive ability to process language must be present; exposure to language must be present; that language must be accessible; there must be interaction with language users in the language being acquired. These four characteristics have great bearing on language acquisition in D/HH children of hearing parents, in particular the last two. Delays in language acquisition common among D/HH children are not only a result of the inaccessibility of spoken language due to their deafness, but are aggravated by the absence of interaction with language users (since D/HH children, under circumstances without intervention, cannot hear or reproduce speech). Subsequently, and in line with the social model of Disability, delays in language acquisition can be seen not as a factor of the child's deafness per se, but rather as a result of the mismatch of hearing status between children and parents, lack of available language role models, inappropriate early intervention, and delays in diagnosis.

The fourth and final significant characteristic of note here is that first language acquisition must occur during childhood. Lenneberg (1967) proposed that there is a critical period within which children can become proficient in their first

language. While there is some dispute regarding the length of this critical period, and an absence of empirical evidence to confirm the theory, it is largely accepted that if proficiency in a first language has not been acquired by puberty, it will not be mastered thereafter. Furthermore, the ability to master a first language deteriorates with time from approximately 7 years of age through to puberty. Indeed, discrepancies have been identified among D/HH children between those with intervention and subsequent exposure to language before and after as early as six-months of age (Yoshinaga-Itano, C., 2004), and earlier exposure to language has also been shown to have long-term advantages in both production and comprehension of language (Morford, J.P. and Mayberry, R.I., 2000).

In summary, language acquisition requires the cognitive ability to process language, exposure to an accessible language, and interaction with language users. For D/HH children born to hearing parents, their inability to hear the spoken language being used in their midst and the immediate inability of their parents to communicate in a language which is accessible to them (such as Sign Language) prevents them from acquiring this language as other children would. Given that language acquisition is not modality specific, D/HH children born to D/HH parents, where Sign Language is the dominant language of the home, acquire Sign Language on par with hearing children acquiring speech. Since there is a critical period for language acquisition, and since research has shown children experience language delay as early as six months old, early intervention for D/HH children is critical. Unfortunately, there are many difficulties in this area in the Irish context, in particular since we do not have universal newborn hearing screening (UNHS). As a result, the first stage in providing appropriate services to D/HH children, which is the identification and diagnosis of their hearing loss, is the first hurdle presented in deaf education.

Identification

There are three main methods with which to identify hearing loss; behavioural, electrophysiological, and electroacoustic (Cone-Wesson, B., 2005). Behavioural methods include observer-based psychophysical procedures (OPP), behavioural

observation audiometry (BOA) and visual reinforcement audiometry (VRA). OPP provides a more reliable and rigorous method of testing in that it attempts to differentiate between reactions from an infant to sound versus random reactions. However, it is largely restricted to research and is not used in a clinical setting. BOA, on the other hand, is widely used in the early assessment of infants. VRA can only be used with children older than four to six months. Hearing is tested in this method by playing a noise and when the infant responds by turning towards the source of the noise a visual reinforcer is activated.

The two main methods of electrophysiological testing are electrocochleography and auditory brain stem responses (ABR). Electrocochleography, which was developed in the 1960s, involves a surgical implantation of a needle electrode into the middle ear which measures compound nerve action potential. While this method is advantageous in that it produces the same results regardless of the age of the infant, the major disadvantage is the expense incurred and the invasive nature of the surgery. Auditory brainstem response testing provides a cheaper non-invasive method. This method measures brain electrical potentials that are produced in the auditory nervous system. They can be measured using electroencephalography (EEG) electrodes placed on the scalp and is therefore a non-invasive method. The disadvantage is that it takes quite a long time to analyse test results (more than an hour for a three or four frequency audiogram estimate). Conductive as well as sensorineural hearing losses can be detected. ABR is commonly used with infants to estimate hearing thresholds.

Electroacoustic methods involve measuring otoacoustic emissions. These are sound emissions made by the ear when responding to sound. Somewhat similar to an echo, they can be measured by a microphone placed at the external ear. If for some reason the outer hair cells (which are responsible for the production of this sound) are not functioning, the echo measured at the external ear will be diminished or absent altogether. This method, although not completely foolproof, measures sensorineural hearing loss and is frequently used in newborn screening. Judging from the variety of methods above, identifying hearing loss has become an increasingly sophisticated technology, with UNHS implemented across much of the

'developed' world (Cone-Wesson, B., 2005) in order to identify hearing loss after birth, allowing for early intervention and thus minimising the educational disadvantage incurred through language delay.

UNHS involves the routine screening of all newborns in hospitals to identify congenital deafness. Since symptoms of deafness often do not present themselves until language acquisition milestones are missed, UNHS greatly improves the chances of providing early intervention to prevent language delay. While some earlier studies showed that the advantages of early identification disappeared by the age of three, these studies focused on intervention provided before and after the 24 month mark. However, more recent findings which have instead examined early identification and intervention provided before and after the six month mark (a much earlier mark than previously used) show a significant and long-lasting advantage of neonatal identification and intervention (Powers, S., 2003). Yoshinaga-Itano (2004) summarises the findings from a series of studies into the efficacy of the UNHS programme across Colorado State in the US on enhancing the language, speech and socio-emotional development of early identified deaf children. Her evaluation of the Colorado Home Intervention Programme (CHIP) through a number of research projects showed that the first 6 months represent a sensitive period in early language development and present a window of opportunity for intervention. Those children identified at 1-2 months, 3-4 months, or 5-6 months all showed similar language development, but 1-6 months and 7-12, 13-18, 19-24 and 25-30 months showed that those identified after 7 months showed language delay. This finding would account for the lack of significance noted by earlier research projects which used 12-month and 24-month markers, since the most significant marker is the 6-month. Yoshinaga-Itano (2004) also notes that the advantage given by early identification to language intervention was related to cognitive development, social development, emotional development and self-concept.

It is at this initial stage that difficulties in the Irish system become immediately apparent. In spite of a great deal of recent campaigning (Deafhear.ie, no date), there is no UNHS in Ireland, a situation that is quite unique in the West. While the Health Service Executive acknowledges that this is best international

practice, and that the screening should be rolled out across Ireland, they have yet to provide a budget to do so (Personal Communication, Brendan Lennon in DeafHear). There are a number of pilot schemes in place across the country, and DeafHear, a national organisation for D/HH people, has purchased the necessary equipment and currently offers a newborn hearing screening service on a walk-in basis in their Dublin office to any parents with newborn children who wish to avail of it. However, at national level the service is not available and as a result the average age of diagnosing hearing loss is much higher than our European counterparts. DeafHear highlight that in Britain the average age of diagnosing hearing loss, since the rollout of UNHS, is 13 weeks. While the small number of participants in my research would not allow for a comparative statistics, the average age among the children involved in this research to obtain diagnosis was 19.4 months⁶ highlighting the serious delays incurred due to the absence of this scheme.

Because of the absence of UNHS, many D/HH children may not be diagnosed until they fail to meet linguistic milestones and parents suspect that there is a problem. While there are health checks at early stages, the rudimentary method used for testing hearing often fails to pick up on hearing loss. The VRA method described above is commonly used in the Irish context with children at approximately 9 months old. Frequently this is the first indication of any hearing loss, at which stage the D/HH child is already suffering the effects of language delay in the absence of intervention. As a result, the delays in diagnosis in the Irish system have a detrimental affect on D/HH children to the extent that they already suffer from language delay by the time they are identified. As a result, by school-age when their hearing peers have fully mastered the language within which education is to be received, D/HH children must undergo intensive intervention in language as well as embarking on the school curriculum.

⁶ This average was calculated using only the first D/HH child to be born in the family, and only those born in Ireland. Children born outside of Ireland are coming through a separate system, and Irish born D/HH children who have an older D/HH sibling will be identified as high risk, tested earlier, and thus do not represent the average situation for screening children.

Academic Considerations for Mainstreaming

Advocates of mainstreaming and inclusion often claim that deaf children benefit, both linguistically and socially, from being surrounded by hearing peers. A variety of studies, however, have shown that this is not necessarily the case (Marschark, M. et al., 2002: 82).

We have already established that because of the mismatch of hearing status between parent and child, coupled with delays in diagnosis, many D/HH children arrive to school already showing symptoms of language delay. As a result of this delay, and often further aggravated by the presence of additional disabilities common to D/HH children and the absence of appropriate intervention, the educational achievement of D/HH children is impacted. As a consequence, D/HH learners have been shown to lag behind their hearing peers across the board (Powers, S., 2003), specifically in reading (Conrad, R., 1979) and to a lesser degree mathematics (Kluwin, T.N. and Moores, D.F., 1989). Holt's (1993) study on the Stanford Achievement Test for Hearing-Impaired, for example, of 6500 D/HH students found that many plateaued at age 17 with an average reading age of 9.5 years. This general underachievement of D/HH learners compared to their hearing peers in reading skills is deemed to be particularly important considering the relationship between reading skills and performance in overall academic achievement. This difficulty with reading as well as with writing also has a social impact considering the importance of note writing for communication between D/HH and hearing people.

Because of the communication issues involved in mainstreaming D/HH children, a number of measures must be taken to ensure their participation in the classroom, usually in the form of resource teaching or Sign Language interpreting. Resource teaching is frequently used to provide pre-tutoring to equip students with an awareness of the subject material before instruction. A Cypriot study (Hadjikajou, K. et al., 2005) among 69 D/HH children following an oral approach in mainstream schools found that such pre-tutoring in either one-to-one or group sessions was essential for the majority of students to enable them to understand, and thus participate in class. When pre-tutoring was available, students self-reported that 64.7% fully understood their lesson, 22.1% barely understood while 13.2% still

could not understand the lesson at all. Without pre-tutoring 53.7% could only understand lessons to a limited degree, while 21.7% could not understand lessons at all. Although the majority of students understood lessons with pre-tutoring, a large percentage of students continued to struggle when this service was provided.

This study is of particular relevance to Ireland since resource hours aimed at pre-tutoring and post-tutoring material is the main service available to D/HH children in mainstream schools. However, it is extremely time intensive and with only 4 hours of resource time provided to profoundly deaf students in the Irish system, with less provided to those with milder hearing losses, the option of pre-teaching the curriculum is restricted. As a result, the participation of D/HH children academically is likely to be undermined. There is also the option of providing Sign Language interpreters, though this is not practised in the Irish context. Where it is practised elsewhere, a number of difficulties have been identified. Academic participation can be challenging due to the nature of interpreting, the time lag involved, and the distance between teachers and D/HH students caused by lack of direct engagement (Ramsey, 1997). In general, while Sign Language interpreting may provide full access to the curriculum content for D/HH, other factors of the academic experience such as direct student-teacher contact, and access to the incidental learning between peers may be missing. The use of Sign Language interpreters also has consequences for the social participation of D/HH students, an issue which will be discussed below.

In spite of the overall conclusion that D/HH children under-achieve compared to their hearing peers, there are a number of difficulties establishing the exact causes of this with a great deal of conflicting research regarding the most significant factors in educational achievement. Perhaps unexpectedly, educational placement and degree of hearing loss are less frequently established as correlating factors with academic success (Powers, S. et al., 1998: 52) and a complex network of other interrelating factors emerge: ethnicity (Wolk, S. and Allen, T.E., 1985); lack of additional disability (Powers, S., 2003); socioeconomic status (Powers, S., 2003); use of English in the home (Powers, S., 2003); parental support (Bodner-Johnson,

B., 1986; Kluwin, T.N. and Gaustad, M.G., 1992); gender⁷ (Allen, T. and Osborn, T., 1984). It is important to recognise the multifaceted and interdependent nature of these factors and the presence of 'surrogate variables' which may mask other unidentified variables such as languages, socioeconomic status, and so forth (Allen, T., 1986; cited in Powers, S. et al., 1998).

Further to this conflicting evidence, there are significant fundamental flaws in many of the testing procedures applied to D/HH children. In their review of 333 research projects into the factors contributing to high academic and non-academic success among D/HH students, Powers et al⁸ (1998: 176) point to the frequent use of inappropriate assessments which may unfairly penalise D/HH children. Most significantly, many standardised academic tests⁹ are based on the English language (or mother tongue of the nation within which they are being administered) and therefore test not only academic ability on that subject area but also language competence. As a result, D/HH children may display poor skills in maths when in fact it is their difficulty understanding English word problems and not mathematical concepts being measured. As well as that, much of the research into language aptitude focuses on English-language as opposed to Sign Language, due to the absence of research in the latter. There is a significant lack of testing tools to measure language competence in D/HH children who use Sign Language as their first language, and in Ireland there are no such tests available in ISL for children (Dunne, S., 2008). As a result, the only language measure available for D/HH children is, for many of them, a measure of their second language and not their first. Also, Powers et al (1998) have highlighted that within language testing, particular language skills are often confused with an overall understanding of the concept of

⁷ Significance of gender in predicting reading skills may be more closely related to the significance of language, since there are frequently differences in languages between D/HH boys and girls with oral language more common for boys and Sign Language more common with girls (Powers, S. et al., 1998).

⁸ Their report focuses largely on research from the UK and the USA, both of which will have relevance for the Irish context since our educational policy is similar. However, their report did not specifically address the issue of cochlear implantation due to time constraints. Since cochlear implantation is greatly changing both the process of deaf education and the academic outcomes, it is unfortunate that it was not a feature of this review.

⁹ The Stanford Achievement Test for Hearing-Impaired which is frequently used in American studies is a notable exception to this.

language. Many tests are administered through speech and therefore are testing lip-reading skills and residual hearing as well as language competence. When Sign Language *is* used in test administration, there is frequently a lack of clarification between the use of native Sign Languages versus forms of manually coded English both in terms of the language being tested and the language used to communicate test instructions. Because of this Powers et al warn that they "have an obligation to place serious question marks by the validity of results regarding language ability, be it spoken, signed, or written" (1998: 33).

In spite of the difficulties mentioned above, there have been numerous studies into the academic performance of D/HH children across placement settings. Powers (2003) noted that while socioeconomic status contributes to academic success of this cohort, is not nearly as significant a factor for 'deaf underachievement' as it is for differences between hearing students' achievement levels. This leads him to suggest that there may be a greater school effect among the D/HH student population. Indeed, there are a number of studies which point to higher achievement in mainstream placements than among those in day and residential settings (Kluwin, T.N., 1993; Kluwin, T.N. and Moores, D.F., 1985). However, Powers (2003) problematises this finding by stating that frequently, background factors are not taken into account and when those factors *are* included, placement is a less significant factor. There is therefore, a problem with the direction of cause and effect when examining academic performance across educational placements.

Frequently, placement is a reflection of the child's academic ability and not vice versa. Students with additional learning disabilities, more profound hearing losses, and those who have struggled in mainstream schools may be moved into segregated educational setting. Conversely, D/HH students without additional disabilities who have high levels of IQ, as well as oral/aural abilities (or potential to achieve these abilities through cochlear implantation) are seen as ideal candidates for mainstream placement. In the United States, demographic material shows that students of white ethnicity are more frequently mainstreamed than those from minority ethnic backgrounds, and that there is a higher occurrence of students from minority ethnic background and lower-income families in segregated facilities

(Kluwin, T.N. and Moores, D.F., 1985). When we compare this to research which shows both ethnicity and socioeconomic status as predictors for academic achievement, we see the complexity of factors at play in the success of students in mainstream placement. Subsequently, it would be unwise to interpret the positive results of mainstreamed D/HH students as a product of their school environment leading Powers et al to conclude that

there appears generally a consensus that investigating educational placement as a predictor of educational outcome per se is no longer worthy of considerable research effort. That broad consensus appears to be based on the general observation that placement is at best a very weak predictor of reading outcome, and at worst necessarily contaminated with other, hidden factors, including most notably a distinct patterning in the placement procedures involved (1998: 53).

In spite of the lack of evidence to support mainstream placement as a predictor of academic achievement, it may be fair to conclude that there are characteristics of the mainstream environment which are conducive to academic success. For example, the mainstream environment is more competitive than that of segregated settings due to higher student numbers as well as the presence of hearing peers. As a result, teachers within mainstream settings frequently hold higher expectations for their D/HH students than those teachers working in segregated settings (Kluwin, T.N. and Moores, D.F., 1985). There may also be greater exposure to a wider range of material (Kluwin, T.N. and Moores, D.F., 1985). Thus, while educational placement in of itself may not be a factor in predicting academic success, an increase in the competitive nature, as well as the presence of high achieving hearing peers may contribute to an environment which fosters academic drive in D/HH students. On the other hand, residential schools with higher percentages of students with multiple disabilities, lower student numbers, and the absence of high achieving hearing peers may hinder expectations for D/HH students. However, while we frequently see academic advantages provided in mainstream environments this is juxtaposed against the poorer social environment for D/HH students within mainstream schools (Gillen, J., 2001; Hyde, M. and Power, D., 2004; Oliva, G., 2004). One participant from Oliva's study summarises the situation as follows "[i]t is clear from my own experience and from those of other deaf kids in mainstream

situations that good academics and crappy social experiences go hand in hand” (2004: 76/77).

Social Adjustment, Participation, and Identity Formation in Mainstream Schools

Many studies have indicated the difficulties involved in the psychosocial aspects of mainstream educational placements for D/HH individuals. Concerns about social adjustment, social participation, and development of identity are frequently cited. In spite of the social aspirations of integration, many D/HH students have described the experience in mainstream as lonely (Kent, B.A., 2003), with feelings of rejection and social isolation (Foster 1988 and Mertens 1989 in Stinson, M. and Liu, Y., 1999). Nonetheless, a number of studies have pointed to the potential social advantages of mainstreaming, with D/HH students accepted by their peers (Power, D. and Hyde, M., 2002), in particular when access to D/HH peers are fostered (Israelite, N. et al., 2002) and the school environment approaches the issue of inclusion as one of membership to the school community as opposed to visitorship (Antia, S.D. et al., 2002). Once again, there is a great deal of conflicting evidence regarding the successful social adjustment of students across different placements. This is more than likely due, as it was in academic success measures, to the complex combination of factors at play. A similar caveat is offered introducing this section. The vast majority of research on the social aspect of mainstreaming is quantitative in nature, employing psychometric testing which is inherently limited in explaining the diverse and complex experiences of individual D/HH students in mainstream settings. Nonetheless, a number of significant themes emerge.

Social adjustment

According to Musselman et al (1996), social adjustment can be measured through frequency of interaction with peers both in class and outside of school, feelings of relatedness towards both D/HH and hearing peers, and perceived social competence. To that we could add an overall sense of belonging to the school community (Antia,

S.D. et al., 2002), high self-esteem (van Gurp, S., 2001), a sense of coherence (Most, T., 2007), and meaningful relationships with peers. Research into social adjustment of D/HH peers in mainstream schools can be broadly categorised into those looking at factors contributing to social adjustment *within* mainstream schools and the effect of placement itself as a factor contributing *to* overall social adjustment. In the first category, low degrees of social adjustment among D/HH students have been linked to the presence of additional disabilities, higher degrees of hearing loss, and younger ages of onset of deafness (Polat, F., 2003). On the other hand, high degrees of social adjustment are significantly related to higher levels of speech intelligibility (Most, T., 2007; Polat, F., 2003), parental hearing status (when parents are D/HH), and high levels of academic achievement (Polat, F., 2003).

Unlike academic success, degree of hearing loss and mode of communication seem to feature as much higher predictors of successful social integration. In particular, speech intelligibility features in many studies of social adjustment (Stinson, M. et al., 1996), with loneliness being cited as related to poor speech intelligibility among D/HH children and the subsequent impact on developing friendships with their hearing peers (Israelite, N. et al., 2002; Most, T., 2007; Polat, F., 2003). This may be related to the growing numbers of students in integrated placements where speech is essential for the development of relationships as well as access to the curriculum. When students interact with D/HH peers, Sign Language competence also has significance (Musselman, C. et al., 1996). Therefore it may not be speech intelligibility per se, but rather the ability to communicate effectively with peers that is at stake. However, since a great deal of integration places the responsibility of assimilation on the D/HH child, they frequently must learn to communicate with hearing peers through speech rather than hearing peers learning to communicate through Sign Language.

Poor speech intelligibility is one of many factors which will impact the development of relationships between D/HH and hearing peers. The lack of deaf awareness among hearing students may be another contributing factor. Yetman's (2000) sociometric study of hearing children's perceptions of D/HH children shows that D/HH children were rarely deemed to be popular by their hearing classmates.

In fact 75% of the D/HH children in the study fell into the 'neglected' category on the sociometric scale, meaning that they lacked friends but they were not disliked (more ignored in general by their classmates). Furthermore, none of the D/HH children involved in the study were in the 'popular' category. This is supported by Ramsey's (1997) year-long observation of 3 deaf pupils in integration programmes whose social interaction (and most likely their friendship base) was overwhelmingly with their deaf peers and those interactions with hearing peers were limited to directive statements. Yetman's (2000) study showed that the level of hearing loss is not particularly significant in determining their level of neglect from hearing peers and that those who are 'only' hard-of-hearing are equally likely to suffer low self esteem and to be rejected by their hearing classmates.

Hung and Paul (2006) reveal more positive findings from their research with 241 hearing students in settings along with D/HH peers with 75% of students have positive attitudes towards their deaf peers. Unfortunately, we are given little information regarding the type of inclusion programmes being implemented in the two schools from which the sample was drawn. Neither do we know the level of deafness of the students with whom they were integrated. Furthermore, there may be issues surrounding the reliability of the data since it may be unlikely for students to express negative opinions towards their peers in a survey specifically designed to examine their attitudes towards that group (*Inclusion of Deaf or Hard-of-Hearing Students Inventory*). Nonetheless, the fact that only 25% of students displayed negative attitudes towards D/HH peers, with only 1.2% of those being strong negative attitudes point at the least to neutral if not slightly positive outcome for inclusion in the schools involved.

Yetman (2000) used a second scale to examine the self-esteem levels of the D/HH children in mainstream settings, showing that D/HH children had significantly lower self esteem in 3 out of 5 areas (academic competence, social competence and behavioural conduct). Her analysis showed that the more hours D/HH children spent in contact with their hearing peers (measuring time spend in regular classrooms versus special education classrooms) the lower their self esteem scores.

This represents a phenomenon called the 'referent group'¹⁰, whereby D/HH children educated with hearing children use the hearing children as their comparison group, where those educated with, and thus comparing themselves against D/HH peers had higher self esteem (2000: 31). While this referent group phenomenon may result in greater levels of academic drive (see above) because of increased competition and exposure to material, it can also result in lower self esteem.

Van Gurp (2001) researched the extent of the referent group phenomenon among a group of 65 second level students across a range of placement settings in British Columbia, Canada. She was particularly interested in academic self-concept across placement settings and found that students in segregated settings had significantly lower self-concept in reading, although there were no significant differences found for maths. It is important to note that the vast majority of students involved in this study were educated in placements where they had access to D/HH peers, in spite of the fact that they may be integrated for several classes. Accordingly, the author suggests that these students in integrated English classes with higher self-concept reading scores are not comparing themselves with the hearing peers with whom they are taught (which would more likely contribute to lower self-esteem score), but rather with other D/HH students who are not in integrated placements. Since integration would require a certain level of ability, D/HH students in that setting would assume their abilities to be superior to those attending segregated classes, thus leading to a more positive self-concept in reading. As a result, these findings may not transfer to students in individual mainstream placements. In spite of the academic advantage of integration, students in segregated settings had higher self-concept on measures of physical appearance, peer relations, and self-worth. While this research points to some advantage in integrating students, it continues to highlight the importance stressed elsewhere of access to D/HH peers for positive measures related to self-worth (Polat, F., 2003).

In the second category, examining the effect of placement itself on social adjustment, Polat's (2003) sample of 1,097 Turkish D/HH students across a range of placement settings in elementary, secondary and high school levels favoured

¹⁰ Others have called this the "Big-Fish-Little-Pond" effect (van Gurp, S., 2001).

residential schools. They found that residential school settings were positively correlated with overall adjustment, social adjustment and self-image. However, mainstream settings showed advantages with regard to the emotional adjustment of students. In contrast, Musselman et al (1996) on the other hand found segregated students to be the least socially adjusted in their examination of 71 students sampled from Ontario. However, they also stressed that these higher scores on social adjustment among integrated students were helped by their continued social ties with their D/HH peers. Both studies also examined communication used in schools (since placement options are frequently along lines of communication choices) as a contributing factor. Polat (2003) found that total communication¹¹ methods outweighed oral, or aural-oral approaches in their benefits for social adjustment. Musselman et al (1996) also found that American Sign Language competence was related to social adjustment of students across all placements in their sample, which is more than likely related to their finding that social adjustment with D/HH peers, which would rely on ASL competence, was positively related to perceived social competence across all placement options. This once again signals the importance of access to D/HH peers regardless of placement option. This will be dealt with in detail below in the section on identity.

While this thesis focuses on primary education, it is important to note that difficulties identified with the social aspect of mainstreaming usually become more pronounced in second level and indeed on to third level education where communication and cultural differences are more significant factors in the development of relationships than they may have been at primary level. When D/HH adolescents are educated together with hearing peers, there can be difficulties for both groups in relating to the other (Davis in Stinson, M. and Liu, Y., 1999). Those D/HH students who have been mainstreamed often find their social interaction at third level difficult, because they are alienated both from their hearing peers and from other D/HH students, because of their lack of Sign Language and

¹¹ Total communication (TC) refers to the educational practice of using a combination of multiple language inputs: speech, Sign Language, signed English, finger-spelling, assistive communication devices, etc, to try and increase the chances that D/HH children will acquire information fully.

exposure to Deaf Culture (Kersting, S.A., 1997). However, D/HH students with speech as their dominant mode of communication seem to have more positive interactions at third level owing to their ability to communicate with hearing peers, though they identify the level of persistence and effort needed to both establish and maintain these relationships (Kersting, S.A., 1997). On the other hand, they viewed D/HH students coming from schools for the D/HH as being cliquish and the lack of shared communication and cultural understanding between the two groups created barriers to meaningful relationships. As Kersting observes:

[f]eelings of isolation, loneliness, and resentment were most intense [for oral students] during orientation and first year, when alienation from the deaf student community appeared to be caused by lack of sign language skills, unfamiliarity with norms and values of deaf culture, and perceived hostility from deaf peers. Simultaneous experiences of separation from hearing peers appeared to be caused by physical barriers inherent in the classroom, residence hall, and cafeteria environments, as well as by discrimination from hearing peers, who tended to stereotype deaf students (Kersting, S.A., 1997: 252).

However, Kersting (1997) also notes that relationships between mainstreamed and residential school students improved significantly in the second year of college by virtue of improved levels of Sign Language among the former group. For many, developing relationships with D/HH peers, though troubling at the beginning was advantageous from second year on. As Musselman et al stress:

relationships with deaf peers are essential to the social and emotional health of deaf persons ... Thus, mainstreamed students, while generally well adjusted with hearing peers, maintained ties with deaf peers that contributed to their overall sense of social competency. Relationships with deaf peers may have been hampered by their poorer ASL skills, and it is possible that increased opportunities to learn sign language might further enhance the overall adjustment (Musselman, C. et al., 1996: 61).

In summary, factors contributing to the social adjustment of D/HH students in mainstream schools, and the effect of placement on social adjustment are complex and multifaceted in nature. While it is difficult to draw general conclusions, it would appear that speech intelligibility, or at least a shared communication system with peers has a strong correlation with social adjustment. So too does having D/HH parents and succeeding academically. Additional disabilities and more profound levels of deafness have a negative impact on social adjustment, probably

due to the added stigmatisation that these bring. While students in mainstream schools show greater levels of emotional maturity than those in residential schools, residential school placements (and more likely the presence of a large group of D/HH peers) have advantages for self-esteem and social adjustment. Most significantly, D/HH students must have access to D/HH peers, a theme which will appear through later sections in this chapter.

Participation

Participation incorporates both academic (see above) and social aspects of schooling, and both are represented in the research. Research on participation frequently examines communication issues, since the nature of communication in the general classroom, focusing as it does on spoken and aural communication, can greatly hinder the meaningful access and participation of D/HH students. Even when a school environment adapts to the D/HH student by teaching through Sign Language, social participation can be limited if there is no automatic approach to teaching Sign Language to all students. Ramsey (1997) found that hearing students, without adequate Sign Language instruction, frequently used unintelligible signs towards D/HH classmates, or when sign communication was intelligible it often consisted of directives. While communication is a significant issue, it is by no means the only barrier to participation for D/HH students.

Barriers to participation can also be created by professional staff, hearing students, and D/HH students themselves (Stinson and Liu, 1999). Stinson and Liu (1999) conducted focus groups with professionals (mainly teachers of the deaf, Sign Language interpreters and note takers) providing support to D/HH students in regular classes as well as carrying out observation in general classrooms and elementary school settings to examine these barriers. In the focus groups, both physical and attitudinal barriers were identified including the layout of classrooms, teaching strategies, hearing teacher and student attitudes towards D/HH children, deficient communication skills among both hearing students and D/HH students, reluctance to participate among deaf students, and D/HH students' perceptions of negative attitudes from hearing peers. This research highlighted that staff hold a

great deal of the responsibility regarding successful participation of D/HH children, in particular how they provide a communicative environment conducive to participation. Furthermore, it showed the extensive role that interpreters have beyond mere translation of material noting that "the interpreter's behaviour seems to be a compromise between encouraging student independence and facilitating communication" (Stinson, M. and Liu, Y., 1999: 198). However, some students were observed to facilitate participation among their D/HH peers, reminding them to contribute, providing cues, etc. This is reminiscent of Ramsey's (1997) observation that interaction between D/HH and hearing peers is dominated by directives and is not particularly rich in nature.

In Stinson and Liu's sample, D/HH students usually made a conscientious effort to participate in class, and almost always used speech in communicating with their hearing peers instead of relying on the interpreter. They sometimes used a combination of speech and sign, but it seemed that the students were positive and confident in their attempts at participating with their hearing peers. The children in Ramsey's (1997) sample were ASL dominant communicators and did not use speech with their peers, a fact which may have influenced the communication trends between these samples. In spite of these positive findings however, Stinson and Liu caution that participation does not necessarily equate with full social integration:

Greater participation may result in better learning by the student and greater feelings of being connected to the class than if there is less participation. Such participation, however, is not at the same level of social integration as acceptance, which is the most valued indicator of integration. At this level, the student is positively regarded by other students and has genuine, rewarding friendships with them ... If students are to develop full social competence, they need to experience mutual, rewarding friendships that involve intimate conversations, reciprocal emotional support, and mutual identification (Stinson, M. and Liu, Y., 1999: 201).

Identity Formation

Issues surrounding identity have received much attention, in particular identity formation in D/HH individuals when they have limited contact with other D/HH peers. The importance of contact with D/HH peers has been highlighted repeatedly (van Gorp, S., 2001) throughout the research, in particular since it fosters positive self-identity among D/HH students, which has become a crucial component of

successful mainstreaming. This has largely been in response to a growing acknowledgement of the existence of a Deaf (Padden, C. and Humphries, T., 1988) or Hard-of-Hearing identity (Kent, B.A., 2003). Historically, since most D/HH children have hearing parents, this identity was constructed, not at home, but rather through contact with D/HH peers, learning Sign Language, and being initiated into Deaf Culture through the residential school system (van Cleve, J.V. and Crouch, B.A., 1989). As a result, the mainstream movement is seen as incompatible with fostering a Deaf or Hard-of-Hearing identity since D/HH children, by virtue of their placement, are segregated from D/HH peers and assimilated within hearing culture. This has led some to suggest that mainstreaming "destroys the embryo of the Deaf community" (Crean, E.J., 1997: 128) and has raised a great deal of concern regarding the psychological impact of mainstreaming on D/HH children.

One indication of the difficulties surrounding identity construction is the reluctance of many young D/HH people to disclose their deafness to their hearing peers. This highlights the stigmatisation, or perceived stigmatisation of deafness within mainstream settings and points to the difficulties young D/HH people may have in forming a positive self-identity in such an environment. Oliva's (2004) part-autobiographical part-empirical report reflected on the responses of 60 D/HH participants who had spent at least 7 years of their primary and secondary education in mainstream schools as solitaires¹². Many participants recounted negative experiences of disclosure which Oliva interprets as a "pervasive sense of shame" (2004: 70). Disclosure may be related not only to fear of stigmatisation from hearing peers (Israelite, N. et al., 2002; Oliva, G., 2004), but also to issues of self-identification as being D/HH and/or disabled. For example, Kent (2003) found that among 52 hard-of-hearing students in New Zealand, 55.8% did not self-identify as having a disability. Kent points to the stigmatisation of disability as a possible cause of this reluctance to self-identify, in particular since self-identifying as being disabled was positively correlated with incidences of bullying. As well as that, he highlights the lack of access to information about cultural Deafness to students

¹² This is Oliva's term for those who are mainstreamed alone, with no other D/HH peers in their school programme.

enrolled in mainstream programmes. Importantly, Oliva discusses how this shame manifests itself in participants not wanting to be associated with other D/HH people:

The deaf people I met ‘talked funny’ when they used speech, and I guess that was scary to me too. But in my heart, I knew that they were deaf and I was deaf. But I wasn’t like THAT! I didn’t want to be like THAT! I didn’t want to be lumped in with THEM. It was like looking in a mirror. Being with them would be admitting I was deaf too, and deaf people *were viewed as flawed in the hearing world where I lived* (Participant response in Oliva, G., 2004: 71 original emphasis).

Sometimes I would catch a parent signing to their child, and my parents would again steer me away. I associated signing with the ‘less fortunate,’ as my parents would always call them. My parents would always say that I was better off, did better, and would always be better and that I wasn’t ‘like them’ (Participant response in Oliva, G., 2004: 71).

Considering the importance of access to D/HH peers already established, those students who deliberately shun D/HH people can struggle in creating a positive self-identity and instead react so negatively towards deafness that they strive not to see it within themselves (Oliva, G., 2004).

Moreover Oliva's research confirms that since social adjustment difficulties worsen through middle school and high school (see above) the need for D/HH peers becomes more pronounced during this period. However, she also states that D/HH children with no interaction with D/HH peers during elementary school who are suddenly thrust into the Deaf Community during middle school or high school may reject their D/HH peers, and that this move may instigate a crisis of identity for D/HH children. Therefore, it can be deduced that fostering relationships between D/HH children and their D/HH peers should begin as soon as possible and be continued throughout schooling, a finding confirmed frequently in research (Israelite, N. et al., 2002; Musselman, C. et al., 1996). However, interaction between D/HH is sometimes discouraged in practice since it goes against the normalising ideals of mainstreaming policy. This brings me to the final section of this literature review: an examination of the power dynamics at play in particular with regard to language policy in mainstreaming of deaf education.

Politics of Mainstreaming

It is common for special educators to place blame for the academic underachievement of the Deaf child on the child and not on the school, as if the audist practices of the teacher and policies of the school could not themselves be the primary reason for academic underachievement. The school, indeed the profession, insists that they are engaged simply in benevolent humanitarian practices in the face of overwhelming difficulties presented by the catastrophe of early childhood deafness (Lane, 1996 in Komesaroff, 2008: 4/5).

The controversy surrounding mainstreaming alluded to already is not confined to academic and social concerns. There are other, more deep-seated concerns about the power dynamics of mainstreaming whereby hearing professionals hold an ever increasing monopoly in the field of deaf education, one which positions them as benevolent humanitarians in the crisis of deafness (see Lane above). Unfortunately, research examining the ideological basis for mainstreaming is overshadowed by the vast amount of quantitative empirical work on the academic and social implications already discussed. Some commentary pieces of note have examined the overall issue of deaf education through a theoretical lens, most notably Lane's critical analysis *The Mask of Benevolence* (1992).

In this work, Lane uses the concept of audism to examine how the Deaf Community are disabled by those professionals employed in the industry of 'deafness'. Audism is the concept that one is superior based on one's ability to hear or behave in the manner of one who hears (Humphries, T., 1977). It is an attitude "based on pathological thinking which results in a negative stigma toward anyone who does not hear; like racism or sexism, audism judges, labels, and limits individuals on the basis of whether a person hears and speaks" (Humphrey, J. and Alcorn, B., 1995: 85). It is characterized in education by claiming the superiority of speech and hearing (medical model) over the use of Sign Language (social model). Lane's (1992) examination of the deaf education system points to mainstreaming as the fourth out of five stages of forced assimilation of D/HH children among their hearing peers. In doing so, he situates mainstreaming simultaneously within the historical medicalisation of D/HH people and contemporary discourses of integration and technological advancement. Lane draws upon Michel Foucault's

concept of biopower to examine the advancement of audism, a technique which will be replicated in the thesis. While Lane's work is a commentary which uses the body of research from deaf education as its source, other authors have conducted their own primary research in mainstreaming with a view to deconstructing the philosophical premises upon which it is based, in particular with regard to language policy.

In her in-depth qualitative research among three schools practising integration in Australia, Komesaroff (2008) points to conflict between the hearing world-view and deaf world-view at play in deaf education. She highlights the dominance of the hearing world-view operating in the Australian system and points to a number of tactics used to promote the legitimacy of that world-view. For example, participants commented on the necessity of hearing teachers in deaf education to "be the ears" for D/HH children, which justifies the absence of D/HH teachers within the system. Furthermore, the use of negative discourses employed to describe the impact of the Deaf Community on the situation of deaf education, alluding to them as non-educators, hijacking, posing a danger, and sacrificing children to their politics. Overall, Komesaroff points to the fact that Deaf Community beliefs are viewed as being "political", whereas hearing professionals working in the area view themselves as value-neutral working on behalf of D/HH children.

In a related area, Ramsey (1997) observed that an ideology of equality in mainstreaming can result in neglecting to address the different learning needs of D/HH children. She provides numerous examples from her ethnographic study in Aspen School (pseudonym) where school rules limit the participation of D/HH children. For example, Aspen school's canteen seating arrangements had children sitting on one side only of a bench to prohibit kicking, an arrangement that was not conducive to sign communication. Allowing D/HH children to 'break' this rule and thus facilitate communication was viewed as unfair preferential treatment from many of the general school teachers and hearing pupils, with suggestions that there was discrimination against *hearing* pupils who did not receive such accommodations. Clearly, an awareness of Deaf Culture and accommodating

diverse learning and communication needs means that treatment of D/HH children may need to be different in order to be equal.

It would appear that there are numerous difficulties in mainstreaming including, but not limited to, the role of D/HH educators in the system, the most beneficial placement for D/HH children and how those benefits are measured, and devising and inclusive practice which is Deaf-aware. However, the common denominator between these difficulties is frequently the role of Sign Language, thus continuing historical debates played out in the field for well over a century. The history of this debate will be discussed in the next chapter but for now it is worth acknowledging Komesaroff's observation that:

[b]ecause language exists within a sociocultural context, it is therefore political and bound up with issues of power. For linguistic minorities, the concern is not only how language is used in education but also which language is used in the classroom. Schools are powerful institutions whose language practices maintain or challenge the positions of particular cultural and linguistic groups (2008: 115).

Although the schools involved in Komesaroff's (2008) study all used Sign Language to some degree, a number of issues surrounding its use were identified. Frequently, it was used as a communication tool, but only to be implemented as a last resort if speech failed. Furthermore, educational professionals involved in the study were of the opinion that it lacked the complexity necessary to conduct education. Such negative views of Sign Language, Komesaroff (2008) believes are influenced by the fact that such a low percentage of teachers are themselves D/HH and native Sign Language users (less than 1% in Australia in 1998). She also points to the low numbers of Sign Language training hours provided in teacher of the deaf training programmes. For example, in 1992 the greatest number of hours provided was in Western Australia at 72 hours of Sign Language training. This pales in comparison to the situation in Denmark where 510 - 580 hours were provided. Examining deaf education as a force of sociopolitical factors as opposed to an issue around individual performance, Komesaroff comes to the following conclusion:

The general failure of deaf students in education can no longer be explained by their deafness, lack of communication in the home, or learning difficulties or disabilities. Given the continued underachievement of deaf students, it is time for teachers to

examine their methods. Criticism of these methods is widespread in the literature and among Deaf leaders and bilingual educators, yet many educators... have failed to modify their methods (Komesaroff, L., 2008: 117).

The most likely reason for this lack of change is the reluctance of hearing staff to master a new language (Marschark, M. et al, 2002) and the fact that the mainstream environment is seen as providing an ideal environment to foster spoken language development in D/HH children, frequently at the expense of Sign Language.

When inclusion of D/HH children in public hearing schools was first tried in the 19th century in the United States, this goal of speech development was paramount (Van Cleeve, J.V., 1993). The torch bearer of that movement, Alexander Graham Bell, stated that "theoretically considered, the best school for a deaf child, is the school with only one deaf child in it [...] one deaf child with an environment of hearing children" (Bell quoted in Van Cleeve, J.V., 1993: 334). Isolation of D/HH children from each other was seen to promote normalization, and prevent the growth of, in Bell's terms, a deaf variety of the human race. As it stands, mainstreamed education continues to promote spoken language interaction between D/HH and hearing children, with hearing children having the task of language role model. The opposite scenario, where D/HH act as role models for hearing children learning Sign Language is much less common, although when it is practised it brings benefits to both groups (Kreimeyer, K.H. et al., 2000). This raises concerns not only about the language development of D/HH children and their future interaction with D/HH peers, but also about the overall foundations upon which inclusion is based.

Since relatively few studies have focused on the theoretical aspects of mainstreaming, in particular language policies and the issues of power and discourse as they are played out in the general classroom, this thesis is taking Komesaroff (2008) and Lane's (1992) works as key pieces in informing and guiding this research. Foucault's writings on discipline, medicine and power are paramount, as is Allen's (2003) discussion on geographies of power. They form the theoretical basis of this thesis and will be discussed in detail in chapter 4. By shifting the focus away from testing of individual students and towards the sociopolitical goals of

mainstreaming, this research hopes to add to the small body of work currently addressing this gap in the literature.

Conclusion

The mainstream classroom has become almost hegemonic as 'the' place where children with special educational needs, including D/HH children, should be educated (Holt, L., 2003). This is supported by local practices, national legislation, and international guidelines. While this integration of D/HH children in mainstream schools is embedded in a rationale of inclusion, tolerance, and academic benefits, international literature would suggest that there are a number of concerns surrounding this development.

First of all, it would be a disservice to D/HH children to suggest that their educational needs are the same as their hearing peers. The linguistic and cognitive impacts of deafness, coupled with frequent delays in diagnosis and service provision and the fact that D/HH children overwhelmingly have hearing parents, means that the educational landscape for D/HH children must be catered to their specific needs. While there are numerous difficulties with assessing the performance of D/HH children, it is safe to assume that they consistently underperform when compared to their hearing peers. The education system must endeavour to close this gap, but will not do so if, contrary to Marschark *et al's* recommendations, they continue to teach deaf children "as though they were hearing children who cannot hear" (Marschark, M. et al., 2002: 134). D/HH children must have successful communication with both their teachers and peers if they are to fully access the curriculum and achieve their academic potential and in the Irish context, poor communication with teachers has been cited as a significant reason for educational underachievement in D/HH people (Conroy, P., 2006). D/HH children *have* specific needs that are different from their hearing peers, and these must be met head on in the education system if the current educational gap is to close.

The social implications of mainstreaming also cannot go unlooked. For D/HH children who have difficulties communicating with their hearing peers, the mainstream environment can be lonely and isolating place. Lack of contact with

other D/HH peers can also contribute to poor self-esteem and confused self-identity. Similarly, if hearing children are not deaf-aware they may be confused as to how to appropriately communicate with their D/HH peers, and may be more inclined to simply ignore their classmates.

In spite of these difficulties, there are many potential benefits of mainstreaming. Children can stay closer to the family home and local community. The academic competitiveness of the mainstream environment can be beneficial, as can the higher expectations of mainstream teaching staff. Symbolically, showing that D/HH children can take their place in the local school and community and that they need not be segregated to a separate educational institution indicates progress in how D/HH people are viewed and bodes well for future relations in employment and social settings. It is significant that the more successful programmes of integration seem to have been those that provide a balance of both hearing and D/HH peers in an environment that is both competitive academically yet mindful of the specific educational needs of D/HH children (the co-enrolment model, see Kreimeyer, K.H. et al., 2000). This can be compared to situations where the ideology of mainstreaming is to take advantage of the spoken language environment, and to promote the normalisation of D/HH children, often at the expense of their academic and social progress. To do so would be to continue with a medical model of deafness, in spite of calls to the contrary from the Deaf Community and international guidelines (UNCRPD).

Unfortunately, there is a great deal of anecdotal evidence in Ireland that the situation at present reflected the latter, whereby mainstreaming is being used to promote spoken language acquisition and does not pay heed to the need for access to D/HH peers. Little research existed, however, to confirm or refute this suggestion. The aim of this study was to examine the current context of mainstreaming deaf education in Ireland in light of the international literature described above, and to unpick the ideologies supporting it. The process of researching this issue is outlined in the next chapter.

3 Transformative Emancipatory Research and Positioning the Hearing Researcher

Introduction

This chapter addresses the epistemological and methodological decisions made during the course of the research process. In particular, it draws attention to the difficulties involved in conducting empowering research with a minority community where there is a history of oppression and as a result, difficult relationships between the researcher's community (hearing) and the researched community (deaf). It addresses the value of an emancipatory framework and the influence of Paolo Freire's *Pedagogy of the Oppressed* (first published in English in 1970) in establishing a positive relationship with research participants. However, due to difficulties which will be addressed below, employing a Freirean methodology was unfeasible and more conventional research methods were implemented, though they were led by a feminist epistemology ensuring that unequal power relations were not reproduced through the research process.

As outlined in the introduction, the objectives of the research were threefold: first, to establish the current policy regarding the mainstreaming of deaf education in Ireland; second, to establish the current practice of mainstreaming of deaf education in Ireland; third, to contextualise both policy and practice of mainstreaming in the larger frame of literature regarding both the history of deaf education and contemporary international best practice. A battery of research methods were used to achieve this. While these methodological objectives made up the empirical data of the thesis, there was also an overarching concern to interrogate and expose the ideological foundations of mainstreaming. The approach to this latter objective will be outlined in the theory chapter (chapter 4).

Power Relations and Research with the Deaf Community

There is an inescapable power dynamic involved in conducting research with a community of which you are not a member, in particular when there is a history of

oppression against that community. As a result, feminist critiques of the power relations (see Kindon, S., 2003) operating within traditional research designs that work to oppress research subjects, particularly those from minority or 'at risk' communities, have been highly influential in this research project, in particular how these criticisms have been incorporated into discussions on research with people with disabilities.

During the late 1990s, there was a vibrant debate on the topic of whether or not non-disabled researchers had a role to play in the Disability Rights Movement (DRM). Authors like Branfield (1998) argued that there was an impossible relationship between non-disabled people and the DRM since, in spite of the empathy non-disabled people could have, their very status as non-disabled brought with it domination, oppression and appropriation. This was in response to criticisms of the "rape model" of research, whereby non-disabled researchers used disabled people as subjects to produce research which would advance their career but provided so little benefit to the disabled community. Shakespeare (2006) highlights that this rejection of non-disabled researchers was widespread at the beginning of the DRM due to the parasitic nature of previous research. However, he highlights that this does not reject outright the role of non-disabled researchers, but rather insists upon a rigorous research agenda which rests in the hands of disabled people, and an accountability to organisations run by disabled people. In particular, Shakespeare criticises the idea that having an impairment is equated with understanding impairment, which he describes as "dangerously essentialist" (2006: 195).

Humphrey (2000) also critiques this essentialism, in particular the tendency of "activists' discourses" to adhere to "the dichotomy between non-disabled and disabled people which becomes coterminous with the dichotomy between oppressors and oppressed" (2000: 64). Highlighting that the social model was established by people with physical disabilities she stresses that quite often, those with less apparent disabilities are marginalised within the DRM. She includes herself, as an ex-disabled person, in this group who occupy a liminal position within the movement. Furthermore, she is concerned that in an atmosphere which states that "lived experience of a given oppression is a necessary if not sufficient pre-requisite

for understanding that oppression and becoming part of the solution rather than part of the problem” it falls into self-contradiction where research about blind people could only be done by blind people, about deaf people by deaf people, and so forth with no one disability sector possessing the lived experience to understand another (2000: 64). She summarises that oppression would be better understood as an experience felt by a wide range of people, not limited to the disability sector, and that this could open up the field of disability studies to draw on benefits from other groups such as the feminist movement or the LGBT movement.

The Deaf Studies discipline has also been susceptible to this form of dichotomous exclusion of hearing people working in the field (Broecker, E.L., 2001), ever-cautious that those who are not D/HH themselves may have tenuous connections to the subject matter and may not work in the best interests of the community they propose to serve. As a result, relations between hearing researchers and the Deaf Community can be fraught, and this research was no exception. This friction can be exacerbated when the researcher has no prior rapport with the Deaf Community, such as a familial connection to the community, but instead whose relationship is primarily on professional terms, as was the case in this research. It is not uncommon, as a hearing researcher, to meet Deaf people who dismiss your work by using the sign HEARING-BENEFIT¹³. This sign, meaning that the hearing person will benefit more from the research than the Deaf Community will, captures not only the frustration experienced by the Deaf Community following years of systematized selfishness at the hands of hearing researchers, but also the difficulties faced by hearing researchers committed to becoming meaningful advocates within the community. The benefits received by hearing professionals in advancing their careers through research done 'on' but not 'with' the Deaf Community has caused a great deal of tension between Deaf people and hearing professionals in this area. Lane et al (1996: 446) discuss this obstacle as being the ‘troubled-persons’ industry borrowing a term from sociologist Joseph Gusfield (1989) to describe professional services designed to "bestow benevolence on people defined as in need” (Gusfield,

¹³ This typeface denotes an English gloss of a Sign Language term.

1989 quoted in Lane, 1997: 156). Among these professionals, Lane includes researchers who "serve not only their clientele but also themselves" (1997: p.156).

Acknowledging therefore, the unavoidable nature of the power relations involved in research conducted by hearing researchers among the Deaf Community, this research is guided by a poststructuralist/feminist epistemology to understand the processes that form and disseminate such power relations. It aims to disempower the discourse/dualism of hearing-normal/deaf-abnormal, propagated especially through the education and health service systems. It is sensitive to the fact that many D/HH adults have experienced oppressive relations with hearing people in these institutional spaces, and as such may be cautious in their future interactions with hearing individuals in positions of power, such as those held by researchers. In light of the debates outlined above on the role of non-disabled and hearing researchers within the field therefore, it keeps in mind the dangers of reproducing institutional power relations through the research process.

The first stage in this approach is to give due weight to the importance of the historical context of institutionalised deaf education, in particular how hearing individuals have come to dominate the field and how 'deafness' as a category has been constructed and pathologised. These issues are examined by conducting a Foucauldian analysis on the history of deaf education (see chapter 5), consulting secondary sources and paying particular attention to the various techniques through which 'deafness' as a category was created and used to pathologise and normalise D/HH individuals (Baynton, D.C., 1996; Coolahan, J., 1981; Crean, E.J., 1997; Gallaudet, E.M., 1983; Griffey, S.N., 1994; Lane, H., 1976, 1989; McDonnell, P. and Saunders, H., 1993; Moores, D.F., 1992; Pollard, R., 2006; van Cleve, J.V. and Crouch, B.A., 1989; Winefield, R., 1987). The theoretical basis for this deconstruction is discussed in detail in chapter 4. I then extend this examination to the contemporary system with a mind to exposing strategies of othering and normalising D/HH children through the mainstreaming of deaf education.

While this poststructuralist approach seeks to provide a greater understanding of the forces, processes, languages and institutions that articulate the ever-changing meanings of d/Deafness, it has been critiqued for its inability to

adequately address the problems of the 'real world' (Hubbard et al, 2002). Indeed this criticism has also been strongly voiced among people with disabilities, and their scepticism that academic research has any real word consequences for people with disabilities (Kitchin, R., 2000). The Deaf Community, parents and teachers involved in this project have all explicitly expressed a desire to see something *happen* following the research. In response, this research was influenced by a transformative-emancipatory paradigm (see below). However, as well as 'real-life' changes, the deconstruction demanded by poststructuralism is viewed as the first step in exposing the nature of power relations, and subsequent oppressions, thus providing the opportunity for systematic change. This systematic change has been targeted in the dissemination of the research, which will be discussed towards the end of this chapter. Thus, this research is influenced by a transformative-emancipatory paradigm and appreciates the necessity of concrete action in the 'real world' lives of the participants, but stresses that such 'action' cannot happen in the absence of theoretical consideration.

Transformative-Emancipatory Research and Critical Pedagogy

Attempting to liberate the oppressed without their reflective participation in the act of liberation is to treat them as objects which must be saved from a burning building; it is to lead them into a populist pitfall and transform them into masses which can be manipulated (Freire, 1970, 1996: 65).

Not satisfied with simply critiquing a particular system as demanded by poststructuralism, the transformative emancipatory paradigm aims to propose and/or instigate changes to improve the circumstances of a given community. A number of concrete actions were taken over the course of the research process to ensure changes to the current experience of mainstreaming. While large-scale systematic change relies on a top-down approach, and cannot take place over a short period of time through the influence of a research project, other smaller changes to the everyday lives of the families of D/HH children were more realistically achieved.

A number of examples include establishing a flow of information to parents on upcoming events or issues that were highlighted to be of concern during the

interview process. Another frequent example was when parents identified isolation from other families with D/HH children as a cause of concern. Often, parents in a given location may not know of other families with D/HH children in that area, itself a by-product of the mainstream system where not only D/HH children experience isolation from their D/HH peers, but also parents from other parents. However, as a researcher in the field, I may have had another family involved in the research nearby. Due to anonymity issues, I had to request permission from parents to provide contact information to others to help establish clusters of support locally. Parents were always willing and eager to have contact with other parents locally. As a result, at least six parents involved in this research have now established contacts locally, often between families with a younger D/HH child and a family with an older D/HH child to provide support during the early intervention phase. Furthermore, there is now an open discussion among parents on the need for a parents' association, and meetings are ongoing in this regard, facilitated by the contacts made in this research process. As well as that, parents are using these contacts to lobby for secondary school services. As such, small measures were taken to provide some form of real change to the everyday lives of participants.

Promoting systematic change is a longer-term goal of this research. However, to ensure that the proposed solutions are arising from the community and not propagating oppression with research that is 'HEARING-BENEFIT' as described above, proposing solutions must be a process which is interactive and participant-led in nature. This aspect of the research has been largely influenced by critical pedagogy theories and the works of Paulo Freire, in particular *Pedagogy of the Oppressed* (1970, 1996). Freire's work views community-based research as a form of education and concentrates on promoting emancipatory research methodologies among whom he terms a peasant class. He critiques the unequal power relationship often present between what is implicitly understood as a middle-classed, educated and perhaps white western researcher working among an uneducated (in the conventional school-based sense of the word) rural population of peasants. While this dualism is not exactly replicated in this research, the inequalities of education attainment between the hearing researcher and the Deaf Community, as well as the

political power differentiation between hearing and Deaf Communities are similar to those critiqued by Freire. Furthermore, as his work focuses on the concept of pedagogy and education, Freire's work is doubly suitable for application to this research project.

Freire has a number of ways of theorising the unequal power relationship between oppressor-researcher and oppressed-researched. While Lane (1992) refers to this as a 'mask of benevolence', Freire discusses humanising versus dehumanising research, with the latter arising from the oppressor-researcher's need to justify control over the research community by controlling the research project through a narrative of generosity, charity, and paternalism:

[i]n order to have the continued opportunity to express their 'generosity', the oppressors must perpetuate injustice as well. (1970, 1996: 26) ... Discovering himself (sic) to be an oppressor may cause considerable anguish.... Rationalising his guilt through paternalistic treatment of the oppressed, all the while holding them fast in a position of dependence, will not do (1970, 1996: 31).

To counteract this phenomenon, which is similar to Gusfield's troubled person industries described above, Freire calls on researchers to engage in a continuous examination of conscience as well as a continuous dialogue with the research community. Freire's definition of dialogue is quite specific, incorporating reflection and action as well as six essential characteristics: love, which is commitment to others and their cause; humility, which is closely linked to co-operation; faith in human kind; mutual trust; hope; and critical thinking. Dialogue therefore calls on researchers to be deeply committed to the research community within which they work, and places a positive relationship between these individuals at the centre of successful emancipatory projects.

In the case of this research, establishing trust with the Deaf Community was a complex and difficult task, but nonetheless essential for conducting this research. While the project itself could have gone ahead without the participation of the Deaf Community, in particular since the vast majority of D/HH children have hearing parents and hearing teachers thus interaction with the Deaf Community was not strategically essential to conduct fieldwork, the resulting project would not only have been unethical but, in Freirean terms objectifying and an act of violence:

[a]ny situation in which some individuals prevent others from engaging in the process of inquiry is one of violence. The means used are not important; to alienate human beings from their own decision-making is to change them into objects (Freire, P., 1996: 66).

In more methodologically concrete terms, Freire aligns dialogue and emancipatory research with the establishment of a content programme. This content programme has three stages. First of all it seeks to establish "the present, existential, concrete situation, reflecting the aspirations of the people" (1970, 1996: 76). Second, it poses the situation as it stands to the people to challenge them and require a response that is not only intellectual but at the level of action. Here we see that dialogue as both theoretical and pragmatic is reflected in the methodology that Freire proposes. Third, Freire challenges us to move beyond mere project design and implementation and states that we must establish the reality which mediates men (sic) and the perception of that reality held by educators and people. Completing this process was unfeasible within the timeframe of a Ph.D, though the Ph.D process itself forms the first of these three stages. However, this research relationship with the Deaf Community is not static, nor is it confined to the years spent enrolled in the doctoral programme. It began prior to, and will continue beyond this timeframe, and therefore Freire's methodology, in particular the need for committed research, is particularly appropriate to establishing long-term goals in emancipatory research with the Deaf Community.

There are obvious difficulties merging such kinds of research with the demands of contemporary academic professionalism, and ultimately this research failed to meet its aspirations to undertake a Freirean methodology. The first difficulty is the expectation of prolific publication and project leadership as an academic, which is an awkward partner with community-led, grass roots advocacy. Sacrifices must be and were made during the course of this research to strike a balance between academic and advocate. For example, the quest for completion in three years was abandoned early on, acknowledging that significant time would be given not only to learning Irish Sign Language but also to establishing a relationship with a community for whom the concept of hearing advocacy is still new.

A second, perhaps more serious weakness is that while the transformative-emancipatory paradigm and Freire's methodology together bring the benefit of lessening the research/subject power divide, they also present problems regarding representation of communities as homogenous entities. Throughout *Pedagogy of the Oppressed* Freire fails to account for the fact that 'the peasantry' may be comprised of heterogeneous groups with conflicting interests, all of whom are oppressed in their own way, and engaged in their own struggle. This research involved a number of different communities; the adult Deaf Community, D/HH children, parents of D/HH children, teachers, each of which has their own agenda and complaints with the system. While it proposed to be participant-led, it became apparent that there were several different categories of participant to consider. Initially, the research intended to prioritise the role of the Deaf Community as this cohort is often excluded from debates on issues that pertain to them and are underrepresented in deaf education literature which instead focuses on parents and teachers. However, it became apparent that similar to previous research projects in the area, parents and teachers of D/HH children were emerging as the more represented group in terms of interviews, contact with the researcher, and overall guidance of this research project. To try and counter-balance this, a number of focus group meetings were held specifically with members of the Deaf Community. Furthermore, significantly more time was spent in informal social contacts with the Deaf Community than with parents or teachers.

For the first year of this research I had extensive contact with the Deaf Community in the greater Dublin area. I attended evening ISL classes during year one and in year two (having completed the top level available in evening classes) I attended ISL classes at the Centre for Deaf Studies in Trinity College Dublin for nine hours each week. Such a significant amount of time was given to learning ISL because proficiency in communicating with Deaf people is essential to facilitate meaningful contact with the community. As Jacquie Sarsby states:

[a] willingness to learn a language may be the most important factor in establishing good relations with informants. Even with the most excellent of interpreters, there is nothing so alienating as to speak another language (1984: 106)

Becoming proficient in ISL makes a statement to the Deaf Community that, not only do you value their language, but you value meaningful communication with them. While there have been a number of successful and important research projects conducted by hearing researchers using interpreters, long-term research projects (such as a Ph.D) warrant a significant commitment on the part of the researcher.

While interpreters are bound by a code of ethics, the Deaf Community in Ireland is quite small and the population of interpreters are well-known to many D/HH people. In fact, many interpreters have D/HH family members or D/HH partners. Subsequently, D/HH people are sometimes reluctant to use interpreters when commenting on personal issues. This is particularly the case if the subject matter involves criticising particular service providers who would be well known to the interpreters. For this reason, interviews with Deaf individuals were conducted through Irish Sign Language and translated into English and transcribed by the researcher. The interviewees were also provided with an option of requesting an interpreter for transcription, and that they could nominate which interpreter they preferred to work with, however none availed of this option, indicating perhaps a preference for complete privacy when the research has competence in Sign Language.

As well as learning ISL, I attended many events organised by the Irish Deaf Society (IDS), the Centre for Deaf Studies (CDS), and DeafHear.ie (formerly the National Association for Deaf People - NAD). During the summer of year two, I volunteered at a summer camp held in Ireland and run by an Irish Deaf organisation. Since the Deaf Community in Ireland is relatively small, my attendance at Dublin events made me known to the Deaf Community on almost a national level, so that when I attended a number of other events outside of the capital, people were often already familiar with my work. I did not receive an immediate welcome and was, on the contrary, often regarded with suspicion. I was asked on numerous occasions what my interest was in the Deaf Community, whether or not I had Deaf family, why I was attending these events, and what I planned to do with my research. After answering these questions, some D/HH people were very welcoming, encouraging me in my endeavours and thanking me for my involvement in the field. There were

a significant number of others nonetheless, usually those who were active leaders within the community or who had more extensive experience with hearing researchers who continued to view me with suspicion.

This suspicion manifested itself in anger that they had yet to see any of my research results (in spite of the fact that it was only year one of my research project), deliberate snubbing at high-profile events, negative comments about my less than satisfactory use of ISL (in particular my constant confusion between American Sign Language and Irish Sign Language), and general negative comments about hearing researchers made in my presence. It is important to stress at this point that I do not highlight these experiences in an attempt to chastise these individuals, but rather as signifiers that there is a real and deep-seated nervousness among many members of the Deaf Community towards hearing researchers that is both justifiable and understandable. While the initial years of my research were difficult not only on a strategic level but also emotionally, midway through my fourth year I was contacted by one such leader of the Deaf Community who met me with the specific purpose of informing me that “the Deaf Community needed hearing friends like me”, and that while it takes time to gain the trust of the Deaf Community, he appreciated my efforts and perseverance.

Perhaps the most difficult aspect of establishing a relationship with the Deaf Community and of engaging in participatory research is the obligation, as a researcher, to critically analyse the community at stake rather than blindly accepting the ‘truths’ they also reproduce. The Deaf Community is itself involved in its own set of power relations, and in particular an emerging strategic essentialism fails to incorporate the fact that there are multiple D/HH identities and that the D/HH experience is not as homogenous as it is often portrayed by ‘the Community’ (Myers, S.S. and Fernandes, J.K., 2009). Many Deaf adults encountered in my research lamented the continued pursuit of speech therapy among D/HH children and indeed promoted the residential school system as the ‘only’ successful option for D/HH children, occasionally referring to cochlear implants as an ‘abuse’ of D/HH children.

However, the current situation faced by D/HH children is substantially different to those Deaf adults, who have learned Sign Language, whose schooling took place in a residential setting and who are assimilated within a Deaf Community. In particular, improvements in technology in recent years points to dramatic changes in the circumstances of D/HH children whereby spoken language acquisition has become much more of an option available to them than it was to previous generations, albeit still an arduous process. The opposition from the Deaf Community towards cochlear implantation, speech acquisition and mainstreaming must be positioned in the context of their own (often sadly oppressed) childhoods, and not necessarily the conditions faced by D/HH children today. Subsequently, while the Deaf Community have the lived experience of growing up D/HH, and since their voice has been traditionally marginalised within the field of deaf education, this research sought to address and include their concerns, but is committed to doing so in a critical manner and one which does not neglect to deconstruct the inner-group power relations which can be as negative a force as those working on the group from the outside.

Power, Gatekeepers, and Generating a Sample

While the reluctance of the Deaf Community to embrace me as a researcher is justifiable given the history of oppressive research, there were other (powerful) groups involved in this research that employed specific tactics of avoidance and non-compliance to exert their power in preventing progress in this project, a move not only unjustifiable but unethical considering the need and governmental obligation to research in this field. The main players at stake were various sectors of the Department of Education and Science (DES), in particular those gate-keeping access to quantitative data on deaf education, and the work of the visiting teacher service (VTS)¹⁴. The main area affected by this gate-keeping was access to quantitative data as well as sample generation.

¹⁴ Notably, similar information in the USA which is gathered on an annual basis with a much greater sample size than Ireland is available publicly and freely online through the Gallaudet Research Institute (<http://gri.gallaudet.edu/Demographics/>).

In the initial project proposal, it was hoped that similar methods used in an undergraduate research project would be employed in the generation of a sample, but that these would be extended to a national level. It was planned to survey each of the 10 regional offices on deaf education (through the VTS), and use these responses to select 3 of the 10 regional areas as my sample areas for study. Three schools in each of these areas would be selected to generate participants resulting in a total of nine schools to be involved overall. In general, the VTS would act as the main contact through which I could reach families and schools with D/HH students. However, it became apparent in the early stages of this research that this method was no longer feasible.

In spite of the creation of this service over 35 years ago, there has been little data gathered on the situation of deaf education in Ireland since. Furthermore, there has been no systematic review of the VTS since then. The manner in which the VTS deliver, assess, and review their service is a largely internalized system with little external accountability. There is no overall service manager, though the establishment of the regional offices from 2004 means that there are now local inspectors with responsibility for the VTS. However, since these inspectors do not have to have any experience of deaf education, the manner of service delivery, and in particular the pedagogical practices of the VTS has not come into question.

As a result of this, the general response of the VTS as a whole to this research has been one of suspicion and caution. Several visiting teachers spoke with concern about the research, either directly to me or through other colleagues, stating that they felt that any research likely to show negative findings in relation to mainstreaming should be conducted internally. Some would not take part in the research because they felt that, in spite of remaining anonymous, they would be identified by their colleagues. Others would only agree to become involved if I received approval from the directorate office, approval that was sought but never granted. Finally, it was recommended to me that instead of seeking interviews I should devise a survey. A survey was drawn up and modified based on feedback from a visiting teacher and from the directorate office, and a request was sent to the directorate to circulate among the VTS via email. After a number of reminder

emails and phone calls, the survey was sent several months later. The response rate was very low and following reminder calls to all visiting teachers¹⁵ it became apparent that the survey was being intercepted at various levels. Some regional managers had instructed their visiting teachers not to fill in the survey. Others directed that no caseload information be provided. In other instances, it was the senior visiting teachers in an area directing to others that no one should return the form. A number of individuals agreed to submit the form after speaking with me, only if they could skip any questions that could identify even the province where they were working.

The VTS participates in research on a regular basis (personal communication, directorate office) but participation entails a service-wide response. However, this is the first time that extensive research has been conducted into the mainstreaming of deaf education and it is possible that this was the reason for their reluctance to participate. Considering also the small size of the field of deaf education in Ireland, it is very likely that individual visiting teachers were familiar with who I was, and in particular that my background involved collaboration with the Deaf Community, sensitivity to Cultural Deafness, and that I was a user of Irish Sign Language. While these are positive traits for hearing researchers to hold from the Deaf Community perspective, it also clearly demarcated me as 'pro-manual' in an often simplified 'manual versus oral' debate where visiting teachers have traditionally been 'pro-oral'¹⁶. Further aggravating this was the fact that I studied for my Masters degree at Gallaudet University, positively viewed as a global capital of the Deaf Community but also negatively regarded as a hotbed of militant Deaf activists. In spite of my relative neutrality (not coming from a Deaf family, being

¹⁵ A small number of visiting teachers were not available at the time of these calls.

¹⁶ The binary opposition of manual versus oral is most unfortunate considering the complexity involved in deaf education. Furthermore, while visiting teachers are traditionally thought of as supporters of oralism, this has changed considerably in recent years, with individual visiting teachers increasingly using Irish Sign Language and supporting families of deaf children using that communication method (personal communication visiting teachers). Nonetheless, there is a long history of oralism from within the visiting teacher service still felt in some quarters. In particular, the association between the promotion of mainstreaming (which inevitably involves a predominantly oral approach) and the visiting teacher service, as well as the absence of D/HH professionals within the fields or even hearing visiting teachers who are competent Sign Language users all aggravate the situation.

D/HH, or working directly in the field of deaf education), these factors may well have contributed to my difficulties in accessing data, more so than might have it been the case were I to have had a different professional background.

Further to this individualised difficulty, there were very pragmatic difficulties with obtaining data through the visiting teachers. The VTS is an itinerant service, without any fixed office through which individual teachers can be contacted directly. The service is managed by the directorate of regional services, which in turn has 10 regional offices. In the first year of this research (2005) I approached each of the regional offices for contact details for the visiting teachers, but was refused access. For the most part, the explanation I received was that the visiting teachers do not have a fixed telephone number, but instead use a mobile phone number, which I was not at liberty to receive. Having made phone calls to all of the regional offices established at the time¹⁷, I was unable to obtain the contact details for any of the visiting teachers. Occasionally, I was given the name of the visiting teacher in the area, but within some regions even this information was not provided. These difficulties may have been due to the fact that the organisation of this service through the regional offices had been newly established at that time, and that a number of regional offices were still without full-time staff. Some staff made statements such as “my list is not updated” or “it can be quite confusing trying to figure out who is responsible for what” (quotes noted during phonecall). Several more were concerned about who I was and what I would do with the contact details: “what do you need it for?” or “who am I speaking to, may I ask”. More likely it was hindered by the fact that there is still (to date) no service manager of the VTS to who centralised enquiries can be sent.

I repeated this request in the summer of 2007 and received replies from six of the regional offices. Three provided contact details for the visiting teachers, one redirected my request to the directorate for which a reply was never received, one informed me that I should contact again in September with a research proposal and

¹⁷ The regional offices were newly established at the time and a few of them had yet to have a permanent residence or full time staff when this initial request was made in 2005.

that my details would be provided to the VTS but not vice versa, and one office refused access to the information:

Dear Elizabeth,
I regret the Department of Education and Science is not in a position to give you the information you require.
Kind Regards, [name removed]
(received by e-mail on the 3rd of July 2007).

Finally, in September 2008 a request was made again to all of the regional offices and a complete and up-to-date list including contact details was provided, though it was too late in the fieldwork process to implement the original research design. It is likely that research beginning now would not encounter these same problems and that they were more a result of the changeover to a regional administrative system. However, there were a number of other barriers which have not improved, in particular relating to data held by the VTS.

Further to requests for contact details, attempts were made over the course of 18 months to acquire data gathered by the VTS annual survey. The VTS is the main specialist service provided from the DES to D/HH children in mainstream settings. Children are referred to the VTS immediately following identification and as a result, the VTS has access to data on all D/HH students currently enrolled in full time public education, including those of preschool age and those in third level education. They reportedly conduct a caseload survey on an annual basis (personal communication, Limerick Regional Office). Unfortunately, this data is not publicly available and in spite of several attempts to gain access to that data for inclusion in this research over the last number of years, it has not been released on the grounds that it was not public information and that it was sensitive in nature. I made numerous attempts to negotiate this, offering to accept purely quantitative data and providing detailed information on how the material was to be used. Using contacts within the DES to try and acquire the material, I was instead engaged in an endless cycle of e-mails and telephone messages that, in the end was fruitless.

I am, to date, uncertain if this data exists. While a caseload survey is meant to be carried out on a regular basis, the lack of a service manager means that it may

not be conducted. As a result, this tactic may be caused not out of deliberate denial of access to data, but rather masking the fact that the data does not exist. One professional (not a visiting teacher) interviewed for this research observed:

over the last couple of years I would have rang up the Department of Education and Science ... looking for figures, but like you said, no facts, no figures, and I wonder actually if this is more of the defensive, this is my cynicism coming into play, I think that it's defensiveness. Part of it is probably that they don't know. I think that they don't know. I think that whatever figures that there are, they don't think that their approach to deaf education is systematic, organised at all. Everything is ad hoc. It's all about "let's make it up as we go along" (Professional 05).

Suffice to say, conducting research into this area is seriously hampered without having access to any of the data gathered frequently by the VTS. The nature of the data gathered is unknown though it is likely to be comprised of typical demographic material such as levels of hearing loss, educational placement, etymology, communication/language use, educational achievement etc. Some data *was* released by the Visiting Teacher Service to the Advisory Committee on Deaf Education which was incorporated into a report in 2007 (see Chapter 4 by Mathews in Leeson, L., 2007) and is included below along with data gathered for this research.

I interpret this non-compliance as exercise of power from the DES who may be reluctant to see deaf education exposed in its current state due to deep levels of dissatisfaction from parents, teachers and the VTS. It is not at all dissimilar from the situation faced by Judge Laffoy, the intended author of what would later become the Ryan Report (investigation into child sexual abuse) who stepped down from her post due to the failure of the DES to cooperate with the investigation process. Other geographers in Ireland¹⁸ have also recently commented on difficulty accessing data from the DES, and it seems that the systematic and systemic neglect from the Department to engage with researchers is indicative of a lack of transparency and a general paranoia towards exposure through research, and places under doubt the commitment of the DES to promoting research in Special Education, as was

¹⁸ A number of presenters at a session on geographies of education during the Association of American Geographers conference held in Washington, DC in April 2010 commented informally on the difficulty of accessing quantitative data on education from the Department of Education and Science in the Republic of Ireland.

mandated by the establishment of the National Council for Special Education under the EPSEN Act 2004.

Data Collection

Due to the difficulties outlined above both in implementing a Freirean approach as well as access to basic data, a mixture of conventional research methods was employed both to source research participants (snowball sampling) and to gather data (interviews, questionnaires, observation). Given that the experience of deaf education is not a fixed reality but rather is contingent on individual circumstances, space and time, triangulation methods were used to obtain “a better, more substantive picture of reality; a richer, more complete array of symbols and theoretical concepts; and a means of verifying many of these elements.” (Berg, 1998: 5). For example, the experience of a D/HH child in a mainstream primary classroom can be significantly different to their experience in second level. Similarly, the perceived experience of the child from the parents’ perspective can be different to that of the teacher’s or pupil’s perspective. Interviews with parents, students, teachers and other professionals were conducted to create a more informed picture of the mainstreaming experience from multiple viewpoints. Furthermore, many participants were interviewed twice to capture how the experience of mainstreaming may have changed over time. All conclusions drawn from these methods were subject to the poststructuralist deconstruction described above.

Problems with Data Accuracy

As well as problems with gate-keeping, there were a number of specific obstacles to evaluating the provision of deaf education in Ireland. These include, but are not limited to, the lack of available data, national and regional variation within the field of deaf education in Ireland, and the variety of sources used in data collection. The section below opens with a discussion on the absence of quantitative data on D/HH people in the Republic of Ireland, continues by looking at issues of variation in practices and even key terms relating to deaf education, and closes with a note on the variety of data sources, and thus methodologies.

Further to the gate-keeping of data outlined above, there is a significant lack of available data on D/HH people in general. In particular the absence of a centralised database containing demographic information on D/HH children, such as the survey information collected by the Research Institute at Gallaudet University annually in the US, means that there is a great deal of uncertainty surrounding service provision for this cohort. Indeed, general statistics on D/HH people in Ireland are thin on the ground. While there are a number of sources of demographic data on D/HH people, they are not particularly helpful. For example, there is a question on the census relating to deafness, but since the retrieved data applies to those with both hearing and/or visual impairments, it is difficult to separate the two groups. The census question 15(a) is phrased “Do you have one of the following long-lasting conditions: blindness, deafness or a severe vision or hearing impairment?” Subsequently, a total figure is provided for quite a large range of people suffering from two very different conditions which makes planning based on this number virtually impossible. The Irish Deaf Society has been campaigning for a number of years for the change of this question along with the addition of a question on use of Irish Sign Language¹⁹. As well as this, a National Disability Survey was conducted in what 2006 using a sample of participants indicated as living with the longstanding health condition or disability in the main census data. However, to date none of the results of this survey have been released. Further to census information, there are problems with the use of other database information in Ireland.

The National Physical and Sensory Disability Database (NPSDD) compiled by the Department of Health and Children for example, has a number of limitations which make using its data problematic. Registration for this database is on a voluntary basis, and since a significant proportion of D/HH people, namely the Deaf Community do not identify as having a disability they may be less likely to register

¹⁹ Two versions of a pilot survey for the 2011 census are now in circulation. Both versions include a question on the language used in the household, which makes specific reference to Irish Sign Language and, if included, would give numbers of the amount of ISL households in the Republic. One version has also divided the question on blind/visual impairment and deaf/hearing impairment into two separate questions which would, for the first time, give us a comprehensive breakdown between these two cohorts.

their information (Doyle, A. et al., 2009). There were 2,357 with 'ear complaints' of whom 1,618 people registered as being deaf or having hearing loss in the 2008 report, a statistic which falls significantly short of other estimates (Conama, J.B., 2008). However, the NPSDD has its strengths, in particular the extent to which it highlights the discrepancies between service provision and need. It identifies the numbers of people waiting for services, for example the 2,188 awaiting speech and language therapy, 986 awaiting audiology services, 352 in need of an ISL interpreting service, 354 for speed text services, 310 for lip-speaking, and 380 for ISL tuition (Doyle, A. et al., 2009). The NPSDD data on educational placement is not particularly useful to this research since it does not distinguish between disabilities, therefore providing no specific data on those who are D/HH.

Further to the absence of available data, national and regional variation in service provision also complicates data collection. The lack of national cohesion in the delivery of deaf education in Ireland means that the practice of deaf education can vary greatly, as can the use of key terms from region to region, or even from school to school. Since deafness is a low incidence disability, there is a small population of D/HH children scattered across the country and specialist services are limited, and largely on a regional level.

Variation between these services is accounted for, to some extent, by differences in qualifications held by staff in each setting. For example, some units for the deaf in mainstream schools have teaching staff who are qualified teachers of the deaf. Others have general teachers with no specific qualifications in the education of D/HH students. Some schools have access to staff with high-level qualifications in Irish Sign Language while other schools have staff with a basic understanding of some signs. Furthermore, while the Visiting Teacher acts as a common denominator between the various schools, differences in preferred methods among Visiting Teachers themselves, and the relative daily isolation of Visiting Teachers from each other result in regional variation in the overall approach to the mainstreaming of deaf education. Therefore, it is difficult to conduct a general overview of a service that has such extreme variation in service provision. This is

further aggravated by the lack of standardised definitions in the field of deaf education in Ireland.

Through the process of data collection it has become apparent that there is a great deal of variation in how some of the key terms in deaf education are interpreted, in particular regarding language and communication. For example, many schools stated that they use Irish Sign Language as a communication method. However, on closer examination it seems their training is often in Manually Coded English Systems, such as signed English²⁰. Similarly, there are schools that have an obvious understanding of the difference between Irish Sign Language and signed English. With this in mind, there could be schools listed as using Irish Sign Language when in fact they use signed English and vice versa. There also seems to be a discrepancy between what is considered language and what is spoken English. Some schools indicated that they use ‘language’ as a communication method, when in fact they mean spoken English.

As well as confusion over language use, categorising students according to hearing loss may prove to be inaccurate. A common practice in some schools is to categorise students according to the level at which they function (aided hearing level) as opposed to the level of audiological deafness they have been diagnosed with (unaided hearing level). For example, some students who are profoundly deaf, but are fitted with cochlear implants are categorised by their teachers as being hard-of-hearing because this is the level at which they function. In fact, in some schools ‘cochlear implant’ has become a pseudo-category of hearing loss in its own right. A potential danger of such categorisation is that staff may lose sight of the fact that students with cochlear implants are profoundly deaf, and functioned at that level before the surgery. Therefore, they may exhibit language acquisition and cognitive development delays akin to other profoundly deaf non-implant students. By categorising these students as ‘hard-of-hearing’ they may, by default, lose out on the

²⁰ Manually Coded English Systems: These systems are not the same as natural signed languages and instead combine borrowed signs from Irish Sign Language (ISL) with signs created for “translation equivalents for English function words (articles, prepositions, etc.) and prefixes and suffixes” (Lane *et al*, 1996: 270). They follow English word order. See McDonnell (1997) for a discussion of this in the Irish context.

intensive attention they need in the classroom. With the above in mind, attempts have been made to ensure that the categories of deafness used in this chapter are according to the child's unaided hearing levels. However, some schools may still have provided inaccurate information. These are only some of the many examples of varied interpretations of key phrases in this field.

The accuracy of data may also be affected by the variety of sources used. The statistical data outlined in chapter 6 was gathered from two distinct sources: the first includes those figures originally submitted by the Advisory Committee on Deaf Education established to undertake a review of education for D/HH students (2001 to 2004) and the second includes updated figures compiled by the author of this research in the school years 06/07, 07/08 and 08/09. Considering that the VTS who hold national level data contributed to this committee up until 2004, it can be assumed that the material included in the first section is relatively comprehensive. However, the data collected in the second section did not have material from the VTS and thus is much less comprehensive in scope. As well as that, data from each relied on a variety of sources ranging from the Visiting Teacher Service to individual schools. While every attempt has been made to have the statistics as accurate as possible, differences in data collection methods between sources, and across educational establishments, make it difficult to ensure complete exactness.

Ethics

This research was subject to approval of the National University of Ireland, Maynooth Ethics Committee. In particular, the inclusion of participants under the age of 18 and the receipt of funding from the National Children's Office required that ethical approval be sought. An application to the University Ethics Committee was made, outlining the main aims of the research, how informed consent would be achieved, how data was to be collected and stored, how risk to participants would be eliminated, and how vulnerable groups would be afforded special consideration.

Informed consent was sought from all participants. The consent form outlined the purpose of the research, how their data would be stored, and informed them of their rights to withdraw their information at any stage up until project

completion. A modified version of the consent form was provided to younger participants, as outlined below (see page 79). The confidentiality of participants was protected by removing the names and coding the interviews. Interview transcripts were stored either in hard copy in a locked filing cabinet to which only I held a key, or digitally in a word document that required a password to be opened. The ethical application outlined that there was no risk to participants from taking part in the research. Special consideration was given to children and members of the Deaf Community by providing materials in alternative formats (simplified English or through the medium of Irish Sign Language). The letter of confirmation of ethical approval given by the University Ethics Committee for the research is in appendix 3 of this thesis.

Sampling

While demographic data was difficult to access, a rich volume of qualitative data was generated through interviews with participants. Nonetheless, it remained difficult to access participants (in particular parents) because of the lack of any database of families with D/HH children, and the nature of mainstream education itself with no identifiable source of deaf education as there was during segregated education. As a result, a combination of quota sampling and snowball sampling was used. Participants were recruited using quota sampling in a number of ways. In the case of parents, letters were sent to all the units for D/HH children in primary schools across the Republic of Ireland (n=8). Furthermore, some contacts were made through a series of information nights. These information nights were advertised in local media, through Deaf organisations, and through local schools and were coordinated to reach research participants and inform the Deaf Community about the research. Five information nights were held across the country in Dublin, Monaghan, Galway, Cork, and Kerry. The night consisted of a brief presentation followed by a feedback session. Questionnaires were distributed along with consent forms in an attempt to gain participants for the research. In total, approximately 120 people, the majority of whom were Deaf, attended these information nights and 12 research participants (hearing parents of D/HH children) came forward as a result.

While information nights provided a means of contacting participants, the most successful means of obtaining participants was through links with the Deaf Community and participation in community events. Members of the Deaf Community who work within schools as ISL home tutors were very helpful in advertising this research with parents. They were also able to identify which mainstream schools in the area had D/HH students in attendance, data which was unavailable from the DES. This facilitation from the Deaf Community only became possible because of the links I had established with many individuals during the first year of the research, highlighting the value of dialogue and trust with the community, and the benefit of allowing methodologies to develop and evolve naturally. Snowball sampling was also implemented when initial contact was made with parents.

Once parents of D/HH had been identified, professionals working along with their children were also contacted to be involved. Mainstream teachers, principals, resource teachers and special needs assistants were contacted in many of the schools where the children involved in the research were enrolled. In cases where parents identified problems with the relationships with the school, no contact was made to prevent any negative impact on the child's experience at school. Professionals working in units for D/HH children were also contacted to take part. They were approached initially with a letter informing them of the research and later with a phone call. A number of other professionals were contacted directly as they were identified as experts in the field of deaf education. Their specific roles are not disclosed to protect the anonymity of the participants. Details on the professionals interviewed for this research appear in Appendix 1.

The term deafness was not defined in recruiting participants for this research. Posters sent to organisations and schools advertised for parents of "deaf or hard-of-hearing children" to come forward if they wanted to become involved in the research. While other researchers have limited their participants using decibel loss categories, this research hoped to highlight that even mild to moderate hearing loss can impact access to the curriculum in a mainstream classroom. In fact, those children with mild to moderate losses who are less obviously 'impaired', may

receive fewer supports, less attention, and slip under the radar with regard to appropriate intervention. Therefore, this research aimed to include *all* children who are D/HH. Nonetheless, the overwhelming majority of children were profoundly deaf (23 out of 25), perhaps because those volunteering for research purposes were more likely to be the families of children with more obvious ‘impairment’. Some schools involved in the research at the time of interview mentioned that they also had other hard of hearing students in full mainstreaming but that they would not be included in this research. Teachers themselves assumed that this research was only for those children who would be categorised as ‘deaf’. ‘Hard-of-hearing’ refers to those children with enough speech and lip-reading abilities to ‘get by’ in the mainstream classroom with the assumption that they do not need much intervention. A future study may wish to focus on those students categorised as hard-of-hearing to see if their experience varies greatly from the profound and severely deaf students, as has been suggested in the literature (Israelite, N. et al., 2002).

All in all, 21 interviews were conducted with parents (some of these interviews being with both mother and father present), 22 with professionals and 4 group interviews were held with children. While a specified number of participants was not predetermined, the final number of interviews was based on interviewing as many participants as I could make contact with during the time frame of the fieldwork. Keeping the number of parental interviews at 21 also allowed me to contact families a second time to establish changes in their situation over time. Professional interview numbers relied largely on the number of parents who had children in mainstream settings and were satisfied that I contact the school to seek interviews with staff there. The number of children involved was determined by identifying those old enough and with enough language development to be informed of, and consent to participation in the research process. Parental consent was also required, with some parents declining to take part. Since children were the last cohort to be interviewed, this group was the most limited by time constraints. Detail on the research participants follows in the next section.

The Research Participants

There were three distinct groups of research participants: parents of D/HH children (n=21, of whom 6 were parents of 2 D/HH children), professionals working in the area of deaf education (n=22, comprising of 7 teachers in units for the deaf in mainstream schools, 5 teachers in mainstream schools, 2 resource teachers in mainstream schools, 2 principals in mainstream schools, 1 special needs assistant, 1 Irish Sign Language tutor, and 4 other professionals working in service provision and research in deaf education), and D/HH children (n=8 children interviewed in four group interviews). These 8 children who were interviewed directly were selected from the total of 25²¹ children whose families were involved in the research. Out of all the parents and professionals interviewed, only 3 were D/HH, reflecting the fact that the majority of parents with D/HH children and professionals working in the field are hearing. Nonetheless, as already mentioned this research was strongly rooted in the Deaf Community to compensate for this imbalance. A basic outline of interviewees is included in appendix 1.

The 25 children whose stories were collected through interviews with the children themselves, their parents and/or teachers were a diverse group in terms of age, ability, rural-urban residences, nationality, linguistic background, and use of assistive technology. At the time of the first round of interviews with parents and professionals, the children were aged between 18 months and 16 years with an average age of 8 years. At that stage, 10 were attending a unit for D/HH children in a mainstream school, 11 were in a full mainstream programme, 1 was enrolled in a school for deaf, 1 in a school for children with multiple disabilities, and 2 were of pre-school age (one would later go to a school for the deaf and the other a mainstream programme). Fifteen of the children had cochlear implants while 10 used (usually digital) hearing aids. In addition, four of the children were from families who had migrated since their birth to Ireland and English was a second

²¹ There were 27 children if we include all D/HH children from the parents interviewed. However, the data from 2 children were discounted because neither of them had attended mainstream primary school and were both in upper secondary school at the time of the first interview. The mother's interview data was included in the research because, as the only Deaf mother interviewed she offered a unique perspective of considering mainstreaming for children who were ISL dominant with no speech.

language in the household. Four had received a diagnosis of an additional disability and a number of others were undergoing psychological testing for intellectual disabilities, a condition notoriously difficult to identify in D/HH children due to the absence of appropriate tests. In spite of their diversity, these children did share a number of common characteristics. They were predominantly profoundly deaf (n=23), though one was severely deaf and one moderately deaf. All of the children were from houses headed by two parents/guardians and while no question was asked directly of socio-economic status, most of the participants were from middle-class backgrounds (living in private homes with access to their own transport and in employment), though their ability to finance private health care services varied and was discussed through the interviews.

The cohort with the most involvement in this research was hearing mothers of D/HH children. While research focusing on parents of children with disabilities as opposed to the children themselves has been criticised in the past, there are a number of justifications for its use in this project. First, very little research has been conducted on this topic in Ireland in the past, and this is the first study on a national scale. For this reason, there is very little information available as to the general experience of service acquisition necessary for mainstreaming to proceed. As parents are the primary coordinators of services for their children they are best able to comment on access to such services. Furthermore, this project focuses on service provision from identification on, and while D/HH children may be able to comment on what their parents have told them of this period in their lives, parents are a first-hand source of information on the topic. Another factor to consider is the young age and language levels of the children involved in this research. Many of the children were in early primary school and also suffered from various levels of language delay. While methodology can be adapted to give these children the opportunity to participate in the research, the experience of accessing services needed to be obtained from parent interviews. Nonetheless, efforts were made to include D/HH children in this project.

Including D/HH Children

Under the United Nations Convention on the Rights of the Child (UNCRC), which came into being in 1989 and was ratified by Ireland in 1992, there is an obligation on the State to give children a voice in the matters affecting them, including research. The four general principles of the Convention are:

1. That the rights of the Convention would be awarded to all children without discrimination.
2. That the best interests of the child take priority in all actions concerning children.
3. That every child has the right to life, survival and development.
4. That the child's view must be taken into consideration in matters affecting them.

A number of changes have taken place in legislation to reflect the Irish ratification of the UNCRC. For example, we have a Minister for Children (from 1997 a Minister for Health and Children), a Children's Ombudsman, and a National Children's Strategy. Under the latter, there is an obligation upon the government to promote research that includes the voices of children. This PhD research was sponsored by the National Children's Office under this directive and is therefore committed on a number of levels to the inclusion of young D/HH people's experiences.

Aside from the obligations mentioned, it is imperative to include young D/HH people in this research as they are a voice of authority on the experience of mainstreaming. While parents are at a distance from what happens in the classroom and teachers are at a distance from what happens in the playground, D/HH students in mainstream schools have lived daily experience of policy and practice. They are a wealth of information and have a unique perspective from within the mainstream classroom: that of a D/HH child working within a hearing environment. Subsequently a number of children were approached to participate in this study. Parents who would agree to be interviewed for the research were approached to give

consent for their child(ren) to be interviewed. A number of parents agreed²² and consent was also requested either in verbal or signed form from the child prior to the interview. Paired interviews were conducted allowing children to have a sibling or a friend present. Interviews were confidential²³ and information was not relayed to parents or teachers. Due to the large geographic area covered in this research, and the time constraints caused by difficulties obtaining research participants, fewer children than was hoped were included in this project. A total of 8 children (seven deaf and one hearing) were interviewed in group interviews either with peers, or in one case with their parents present.

Interviews were either conducted in spoken English, Irish Sign Language or a combination of both. In the case of children using spoken English, some props were taken to help instigate conversation (for example photographs taken of the child's classroom) and to explain the purpose of the research. A specially designed child's consent form was used with younger participants (n=3), which featured short simple sentences heavily illustrated with images. The consent form was read or signed to the child, and explained in detail, allowing them to ask questions and make comments before they signed it. These 3 younger participants were also given a signpost with a stop sign (similar to a traffic stop sign which would be familiar to them) which they could use if they wanted to take a break, or if they didn't want to answer a particular question. While this prop was mostly used in a joking manner, one child used it to stop a particular line of questioning, and eventually to terminate the interview because he was tired. A number of teenagers were also interviewed (n=5).

Article 12 of the UNCRC notes that due consideration should be made in relation to the age and maturity of the child. Because of the issues of language delay with D/HH children, and also because of the more limited experiences they have growing up (Marschark, M. et al., 2002) they sometimes lack the maturity of their

²² Some parents disagreed, and others who agreed were not followed up with an interview due either to time constraints, distance, or the fact that their child was at too early a stage of language development for the particular form of data gathering.

²³ There was one exception, where the parents were present for the interview at their request. The data gathered was interpreted with the acknowledgement that this child's responses were obviously altered because of his parents' presence.

hearing peers. To address this, and to provide for some sort of retrospective analysis on primary level mainstreaming, a number of second level D/HH students were interviewed to obtain their experiences with mainstream primary school. Three of these young people were in a specialised programme for D/HH students at second level and one was in a mainstream second level school. The three former students were competent ISL users and the fourth used speech solely for communication. Instead of the child-adapted consent form, these teenagers received individual letters in the post explaining in simple English the purpose of the research and what the interview would involve. They also received a slightly simplified version of the adult consent form which they signed prior to arrival. Information was provided on the purpose of the research again when we met face-to-face and an opportunity was given to ask questions. Because the sample size was so small, and only three geographic areas were represented, the child interviews have little external validity. Nonetheless, they provide a rich source of data on the first-hand experience of mainstreaming.

While data gathered was rich, the adult-researcher/child-participant dynamic was difficult to counteract, and the interviews were characterised by a feeling that the young people were trying to provide me with the 'right' answer. While further questions allowed for some of these issues to be teased out, in a future study several interviews over a longer period of time may help to lessen this effect. The focus group interview format was also more valuable in ascertaining honest responses, where one participant could contradict the other if an unrealistically optimistic sense of the experience was being portrayed.

Data Generation

There were three main stages of data collection. First, in order to establish the policy guidelines for mainstreaming of deaf education in Ireland, any relevant legislation along with educational circulars were analysed. These documents were read closely to establish a) the rights of the various parties involved (parents, children, and schools) and b) who was responsible for the provision of those rights

(Department of Education and Science, Department of Health and Children, and so forth).

With the rights and responsibilities of service provision established, the second stage of the research was to examine the practice of deaf education. Information was gathered using questionnaires, interviews, non-participant observation, and focus group meetings. Three different questionnaires were used to obtain data from the Deaf Community, professionals working with D/HH children, and parents of D/HH children. The questionnaires were distributed at the information nights, and a number of individuals requested the questionnaires personally having been told about them through other networks. The response rate was quite high given that the questionnaires were answered during a break during the information night. The questionnaires used a mix of open-ended and closed-ended questions gathering basic demographic data as well as some qualitative information on their experience of education.

The questionnaires for both the Deaf Community and professionals working with D/HH children were primarily used to gather opinions on the mainstreaming process. Members of the Deaf Community were also asked to reflect on their own educational experience by indicating their levels of satisfaction with both the academic and the social content of their education across a variety of school placements. This information was gathered because there is a great deal of anecdotal evidence in Ireland the D/HH adults have been unhappy with the education they have received, and that their poor educational attainment has had impacts on their access to employment (Conroy, P., 2006). However, there is little documented evidence of this dissatisfaction. It is also important to establish the retrospective experiences of D/HH adult as they came through the education system, as this could be used in the future planning of better education services for D/HH children. Professionals working with D/HH children were largely asked to comment on the provision of various services within the mainstream system. Parents of D/HH children were questioned on their access to, and satisfaction levels with identification and service provision. There were no restrictions placed on people answering more than one questionnaire. For example, a D/HH adult who was also

the parent of a D/HH child and worked in deaf education could answer all three questionnaires. As there was no overlap of questions between the questionnaires, material is not duplicated.

Overall, the number of questionnaires returned was relatively small (circa 40) and data gathered in particular from the Deaf Community indicates that there may have been problems understanding the questions (deduced from the 'wrong' type of answer provided to particular questions). This finding is not unsurprising given the difficulties in literacy among the Deaf Community, and was known prior to questionnaire design. However, the questionnaires were merely a means of obtaining some superficial data and the data gathered was supplemented considerably by the feedback sessions following the information nights. As a result, most of the data collected from the questionnaire does not feature in this thesis. Some data gathered was unproblematic and results were analysed using SPSS but was used largely to influence interview questions and analysis of same.

The most significant form of data collection was interview, with 21 parents, 22 professionals and 8 D/HH young people giving a large volume of interview material. Interviews ranged from 30 minutes to 2 hours. Parents were interviewed in person at least once, with a number of parents being interviewed on multiple occasions and all parents being contacted at least once more to obtain an update on their situation. A sample of the typical interview format undertaken with parents is given in appendix 2. Interviews were conducted in spoken English, with one Deaf parent interviewed in ISL. Interviews were recorded, transcribed and then coded and analysed using Atlas.ti, qualitative data analysis computer software. Codes were based on recurring themes from the interviews and reflected both quantitative and qualitative data and both empirical and theoretical concerns.

Non-participant observation was used in conjunction with interviews to provide multiple views of the mainstreaming process. In particular, when used in the classrooms it helped establish the day-to-day practice of mainstreaming deaf education as well as highlighting discrepancies between what parents and teachers reported in interviews and what happened in practice. During observation, a quick sketch of the classroom layout was made to establish seating arrangements, location

of windows, and to notice physical features such as floor surface, blinds or curtains on the windows, high ceilings, and other factors that may contribute to the acoustic levels in the classroom. The physical layout of the classroom can impact not only the level of sound quality received by D/HH students, but also the level of interaction that they may have with their fellow classmates. Seating arrangements conducive to communication between D/HH individuals emphasise eye contact, and a radial view of the classroom and other students. Students seated in small clusters, on the other hand, are not conducive to interaction on a full class scale. In those settings, it is difficult for the D/HH student to follow who is speaking and to face the speaker in time for lip-reading.

Observation is also important in that it establishes how services are used within the classroom. For example, a sound field system may be installed in the classroom but if the teacher does not use it on a consistent basis it is of no use to the D/HH student. Similarly, factors such as class size, the level of activity within the classroom, the teaching style used, and so forth can all affect level of access to the curriculum for D/HH students. Conducting observation provides rich data that can be used to situate data provided by teachers, parents, and students in interviews, as well as providing some interesting interview topics. It also provides an opportunity to see the student's level of interaction with other students in the classroom.

Data Analysis

Following data collection and the basic coding and analysing of interviews and field notes, major themes were identified and placed within a larger context of the history of deaf education as well as current literature in the field. Throughout the interviews and interactions with the Deaf Community, the issue of language use (oral versus manual) emerged as a continuing area of political tension. This was no surprise given the long history of this controversy (see chapter 5 history chapter) and the continued fragile status of ISL in the Irish context (see chapter 7 reproducing power). As a result, concepts of power and resistance and both the role of language in reproducing those relations and how those relations come to act upon language became central concerns of the thesis. The various theories implemented in

analysing those aspects of the current system are dealt with in the next chapter and steer the narrative of the remainder of the thesis.

Conclusion

The field of deaf education is monopolised by hearing professionals, hearing researchers, and hearing policymakers. Often these professionals have not taken an approach sensitive to the Deaf Community or their wishes for the future of deaf education. As a result, embarking on research within this field must be placed in the context of this history and the subsequent impact on relationships between hearing and D/HH individuals. To develop a research project that would be self-reflexive and critical, a Freirean approach was chosen, though a number of barriers such as time constraints and community relations made following his methodology particularly problematic. Eventually, a self-critical research process was followed, sensitive to the traditional power hierarchies not only between researcher and research, but also between hearing and Deaf communities.

To be a self-reflexive researcher presents difficulties itself. Establishing trust with the community (especially with the language barrier involved) cannot be rushed and balancing that relationship with the expectations of academic professionalism can be daunting. Nonetheless, the benefits to be gained from conducting ethically informed research are to be found not only in improved access to participants in data, but also in the knowledge that this research works to rebalance a historically oppressive power relationship through empowering the Deaf Community and their advocates. Of course, working on 'that side' of the divide results in a degree of retaliation from those who traditionally monopolise deaf education services. As a result, a battery of traditional research methods was used, concentrating primarily on interviews as a means of data collection.

Over 50 interviews were conducted giving rise to a rich volume of information on the situation of deaf education in Ireland. These interviews were read with sensitivity to the history of deaf education, and the ideological struggle surrounding mainstreaming. The main themes that emerged pointed to a continued hegemonic medical discourse of deafness in the system in Ireland, contrary to the

ideals of inclusion as fostering a social model of disability. This construction of a hegemonic medical model is the central theme of this thesis. The coming chapters discuss how that model was established historically (chapter 5), how it is reproduced in the current system (chapter 7) and how it has been and continues to be resisted (chapter 8). Since power relations have emerged as a dominant theme for this research, the theoretical underpinning is informed by discussions on domination and resistance. The next chapter discusses these theories in detail.

4 Theorising Power

The institutions central to our society are not spatially fixed neutral entities, but are highly loaded, contested, multi-spatial sites that are often used as a tool for achieving specific political, social and economic goals (Green, A. et al., 2008).

As noted at the end of the last chapter, the vast majority of the research on deaf education is empirically based, quantitative in nature and frequently conducted through standardised testing procedures (founded on the concept that there is a 'norm' against which we can compare the performance of D/HH children). Less work has been done to shed light on the institutional workings of deaf education and to deconstruct the ideologies of mainstreaming. On the contrary, they have largely been viewed as 'neutral entities', contrary to Green et al's statement (above). As Branson and Miller note:

[t]he histories of deaf education ... failed to place their histories in wider historical contexts to understand developments associated with the transformation of deaf education in terms of wider pedagogical and philosophical movements. In stark contrast to, for example, Foucault's histories of insane asylums, medical clinics, prisons, and sexuality, these histories of deaf education also do not consider their particular case studies of the history of deaf education in relation to the wider conceptual transformations of the societies in which they are set (Branson, J. and Miller, D., 2002: ix/x).

While this absence has been addressed somewhat by Branson and Miller and that of others (Baynton, D.C., 1996; Lane, H., 1992; McDonnell, P., 2007), this work has rarely been extended beyond historical analysis (with the exception of Lane, 1992). Also, though Foucault is frequently cited, such analyses rarely explicitly engage with concepts of power and resistance but rather conduct their own 'genealogies' of deaf education. In response, this thesis illuminates not only how mainstreaming is proceeding in practice, but also the ideological processes involved and how these come into force through a continuous negotiation of power relations between professionals, parents, advocates, members of the Deaf Community, and D/HH children themselves. This chapter provides the theoretical basis from which the results chapters proceed.

Geographies of Power

Reflecting on the treatment of power in geography, Sharp *et al* come to the conclusion that:

how power is construed and located remains fundamentally unchallenged, and the centrality of the state and its ability to harness legitimacy, together with the notion that power is rooted in particular institutions, remain largely unquestioned assumptions (2004: 4).

In response to this criticism, there has been increasing debate on the theorisation of power and it is now widely recognised that power is a relative concept, contingent on temporal and spatial conditions. Allen's (2003) analysis of the spatialities of power highlights the development of more complex, though increasingly less spatial conceptualizations of power. In broadening how power is examined away from an absolute concept to one that is relative, examination has also shifted from the simple distribution of power to a more critical understanding of how power is practised (Sharp, J.P. et al., 2000b). This created a turn on how power was examined, opening the debate to the unobservable as well as the observed, introducing the role of ideology in power, and highlighting the messiness of the conventional domination/resistance binary (Sharp, J.P. et al., 2000b).

In his chronology of the various theories of power (in particular as they relate to spatiality), Allen (2003) traces the development from a traditional concept of power as 'centred', moving in a linear fashion from the core to the periphery, through to a Foucauldian/Deleuzian form of immanent power which is at all times everywhere and nowhere. Traditional concepts of power frequently align power with domination, indicating an asymmetrical relationship of command and obedience. Power, as centred, suggests that it is "delegated or distributed in a relatively straightforward manner going through an organizational hierarchy under clear lines of authority" (Allen, J., 2003: 15). This quantitative form of power as capacity gives the impression, according to Allen (2003), that the outcome of a particular scenario can be predicted by measuring who has 'more' power in store.

A more complex understanding of power would include those put forward by Parsons, Giddens, Mann and Arendt (Allen, J., 2003) who view power not as a

capacity that can be held, but rather as the mobilization of resources to achieve a particular outcome. In this instance, power is not always negative and can instead be used by collective agents to secure a particular result. Like the resources upon which it depends, power can expand or contract, and Arendt (in Allen, J., 2003) would argue, diminishes entirely when a collective group disbands. Reflecting on power as mobilization, Allen differentiates between two distinct forms of power: power *to* (get things done) and power *over* (another). In general terms, one can be seen as constructive, the other destructive. In spite of the increased complexity of the ideas put forward by those like Parsons, Giddens and so forth who subscribe to power as the mobilization of resources, Allen states that they are responsible for

clouding the whole issue by creating the impression that power as well as resources actually flows or circulates over tracts of space and time...it is a fiction to suggest that power flows in analogous ways. Power...is not some 'thing' or 'attribute' it cannot be possessed as resources can; and it does not travel (Allen, J., 2003: 63).

To develop this concept further, Allen turns to Foucault's work on discipline and governmentality where power becomes 'an immanent affair'. Here, the focus is less on who has power or 'where' power is located, but more on the techniques of power. Power, in this instance, becomes invisible and is seen only in its effects, which are inseparable from the techniques bringing them about. One of the more important aspects of the Foucauldian concept of power as it is understood in his works on government is the apparent 'freedom' of subjects. Beyond the walls of any given institution, where power as well as its techniques and effects were more visible and spatialised, power as governmentality seeks to control actions through self-regulation, self-discipline, all the while suggesting that the actions of subjects are of their own free will. As such, "power is something that works its way into people's lives through their acceptance of what it is to be or how they should act within particular contexts and scenarios" (Allen, J., 2003: 76) and for this reason, complicity is a central component of the operations of power as an immanent force.

In spite of the illusion of freedom however, the possibilities of what can be chosen are all the time narrowing (the effect of power), which brings Allen to the conclusion that Foucault's power represents a form of inducement. However, such

power can become all-encompassing, making it impossible to disentangle ‘free acts’ from those which are caught in the immanent techniques of subjectivity, creating the danger that any act can be read as an effect of power:

to assert...that there are as many forms of power as there are types of relationship, is to ignore what is *specific* to power as a social relation: *it is to lose sight of the different modalities through which power is exercised* (Allen, J., 2003: 100 original emphasis)

Allen is also critical of Foucault’s lack of attention to the details of different forms of power in governmentality stating that “[t]he inability to distinguish between the different ways in which power may be exercised or, worse, the inability to determine what is not a relation of power, in my view, seriously weakens Foucault’s analytics” (Allen, J., 2003: 78).

As well as Allen's concern on the lack of specificity that Foucault's analytics provide, there has been criticism of Foucault’s failure to account for practices of resistance. However, as Gore points out “Foucault’s modern disciplinary society is gloomy only if the very presence of power...is troubling” (Gore, J.M., 1998: 248). Her counterargument is that:

[p]ower’s pervasiveness, then, seems to be a problem primarily for those who would wish to remove power, because they continue to understand it as somehow sinister, rather than embracing Foucault’s point that ‘a society without power relations can only be an abstraction’ (Gore, J.M., 1998: 248).

She further argues that Foucault was not advancing a concept of power that leaves no room for activism or change. Taking the example of power across pedagogical sites, Gore (1998) argues that they are indeed saturated with relations of power, but that this does not rule out the possibility of change, concluding her article by saying “the Foucaultian approach enables us to document what causes us to be what we are in schools, and hence, potentially, to change what we are” (Gore, J.M., 1998: 249).

Another dilemma presented in adapting the Foucauldian analysis is what Allen refers to as 'lost geographies of power'. Unlike Foucault's earlier work on institutional spaces where the spatio-temporal arrangement of the techniques of

power are made explicit, the same arrangements for dispersed populations are not elaborated upon (Allen, J., 2003). Allen summarises his argument saying:

[w]hilst 'centred' views of power have yet to recognize the problem, the challenge for those who hold that power has an immanent presence is to grasp how, in the context of a diffuse population composed of a multitude of wills, the subject and power remain mutually constitutive of one another in space and time (Allen, J., 2003: 86).

This criticism is particularly relevant to this research considering Foucault is being implemented in analysing the impact of mainstreaming (thus creating a 'diffuse population'). As a result, it is mindful of the need to spatialise Foucault's analytics and does so by examining how medicalised discourses of deafness operate outside the walls of the institution in an education system which has become decentralised or dispersed.

Foucauldian Geographies of Power

This thesis uses Foucault's writings on power and the subject (Foucault, M., 1965, 1976, 1977b, 1977c, 1978, 1982) to shed light on the current system of deaf education in Ireland, in particular how a hegemonic medical model of deafness was established, and is reproduced and resisted in the Irish context. Therefore, it also incorporates Foucault's writings on the history of medicine (Foucault, M., 1976, 2002). Taking Foucault's concept of power as having both positive and negative attributes, with individuals and groups in a constant process of both undergoing and exercising power (Sharp, J.P. et al., 2000b), the intention is not to criticise those working under a medical interpretation of deafness, but rather to examine how that model has become hegemonic with little room for alternative discourses of d/Deafness in the current system.

A great deal of Foucault's work focused on the processes of power though Foucault himself saw his work more as a study on "creat[ing] a history of the different modes by which, in our culture, human beings are made subjects" (in Rabinow, P., 1984: 7). This 'objectification of the subject' has three stages: dividing practices, scientific classification and subjectification (Rabinow, P., 1984). Dividing practices refers to how the subject is objectified by a process of division either

within himself or from others (Rabinow, P., 1984). Scientific classification describes methods of enquiry “the modes of inquiry which try to give themselves the status of sciences...the objectivizing of the sheer fact of being alive in natural history or biology” (Rabinow, P., 1984: 9). Finally, subjectification refers to “the way a human being turns him- or herself into a subject” (Rabinow, P., 1984: 11).

These stages are not independent of each other, but rather swap characteristics and flow into each other. Nonetheless, there is a general chronological development from dividing practices starting in the 18th century, through scientific classification of the 19th century, to more recent processes of subjectification (see figure 4.1 below). Furthermore, there is a development in the scale at which these forces take effect upon the body moving from large scale control (confining the entire body in dividing practices) to small scale control (containing and training thoughts in the mind in subjectification). This is mirrored in the location at which control is exerted moving from external control (again focusing on the exterior of the body or space the body occupies) to internal control (controlling the mind, how the body functions and behaves in space in quite minute detail).

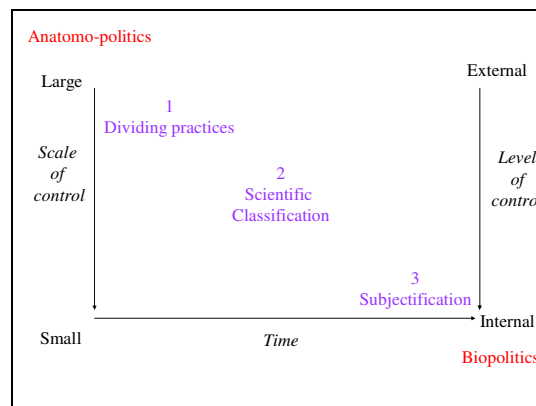


Figure 4.1. Foucauldian processes in the creation of a subject.

Foucault categorised these different forms of power into two distinct eras: the period of anatomo politics where power was concerned with the physical body (body as machine), and the period of biopolitics where power focused on the body as a species (Foucault, M., 1978: 261/262). The former relied on more explicit forms of

punishment, as a warning and thus incentive to comply among the populace. This developed into a more sophisticated form of control, involving an element of spatial organisation through the development of institutions. Heedless of the fact that these institutions may have been dispersed across regions (away from a national 'centre' as it were), power remained 'centralised' with each institution symbolising a location of power. Developing beyond this, biopolitics and bio-power (governmentality) disperses power to such an extent that it becomes internalised, encouraging self-regulation and self-governance without the need of a particular spatial institution of domination. While this internalization of discipline began in a concrete spatial environment, represented by Bentham's Panopticon, the Panopticon has now become more metaphorical in nature, and though its architecture may be increasingly dismantled in an age of deinstitutionalisation, the ideology remains. It is this shift from anatomical politics to biopolitics which creates the difficulty with space in Foucault's third stage. As power becomes invisible, seen only in its effects, the role of space and time on the relationship between subject and power becomes difficult to analyse (Allen, J., 2003).

To counteract this, I am interested in examining how relations of power in the reproduction of a hegemonic medical discourse of deafness are enacted both spatially and temporally under mainstream education. Specifically, I argue that centralised institutions still have a significant role to play in establishing dominance in the power relations between medical and social discourses of d/Deafness. Through the use of subjectification, the dominance established within these institutions is carried across space and time through the use of a negative discourse of Deafness (and as we will also see, Sign Language) which D/HH children themselves will come to reject.

In conducting a Foucauldian analysis on deaf education in Ireland, I am mindful of Allen's (Allen, J., 2003) concern about the lack of specificity in Foucault's analytics and have found, like Gore (1998) that some other Foucauldian analyses have tended to make tenuous links between all relationships and relations of power. As a result, in addition to examining the situation of deaf education through a Foucauldian lens, the more specific modes of power outlined by Allen are

also implemented to bring more focus to strategies at play (discussed below). Thus, while this research acknowledges that there are limits to Foucault's concepts, it is reluctant to move away from his analytics altogether. While this thesis errs on the side of caution and attempts to read only those encounters more explicitly indicative of power relations in its analysis, thus avoiding seeing power in *all* relations, it recognizes that there is a particular strength in Foucault's work in its ability to analyse the operations of power at both micro and macro levels simultaneously, individualising and totalising as it were. Furthermore, his approach to specific institutions (the prison, the hospital, and so forth) along with concrete examples of how these techniques of power function is appealing, especially considering the significance of particular institutions in the history of deaf education.

As well as this, the chronology of Foucault's analysis on power moves from spatially specific sites of control such as the hospital (Foucault, M., 1965) or the prison (Foucault, M., 1977b) to spatially dispersed forms of governmentality through biopower in the modern state (Foucault, M., 1982). Foucault's chronological progress therefore mirrors the progress of deaf education from spatially specific sites to dispersed forms of education, with children traditionally segregated and confined in particular enclosed spaces (work houses, asylums, and later schools for the deaf) now moving toward the integration of deaf children in their local community. This thesis hypothesises that this change in the geography of deaf education will be matched with a change in relations of power, from traditional forms of disciplining the body to biopower.

Modalities of Power as Domination

In line with Sharp, *et al* (2000b) and Allen (2003)'s discussion above, power cannot be understood simply as an all-encompassing dominating force over an oppressed populace. Rather, it must be examined as a relational effect of social interaction wherein power in its various guises (e.g. violence, domination, authority, coercion, manipulation, seduction, inducement, persuasion) is engaged in a constant struggle with resistance in its numerous forms (e.g. non-consent, non-cooperation, disobedience, protest) (Allen, J., 2003) producing a complex entanglement of

power/resistance (Sharp, J.P. et al., 2000b). These various modalities of power are both discursive and material in nature.

The discursive nature of power has become a popular area of examination in recent decades, though definitions remain inconsistent (Cresswell, T. 2009). In general it comprises of "a specific series of representations, practices and performances through which meanings are produced, connected into networks and legitimised" (Gregory, D., 2000: 181). While discourses can be analysed from multiple perspectives, in the context of this thesis I understand it through a poststructural lens, influenced in particular by Foucault. For Foucault, the production and reproduction of discourses leads to the creation of 'regimes of truth', closely related to demarcating what is acceptable or normal and what is not. As a result, the production, reproduction and contestation of various discourses cannot occur in the absence of power relations, for they involve the legitimisation of certain perspectives over others. With regard to discourses of d/Deafness then, these discourses carry multiple meanings and are in a constant state of reproduction.

Historically, medical discourses have arisen from institutional spaces such as residential schools for D/HH children, audiology clinics, hospitals, and more recently, cochlear implant units. Similarly, social discourses had their origins in residential schools, as well as clubs, societies, and organisations across a range of scales from the local Deaf sports club to the global World Federation of the Deaf. Both medical and social discourses of d/Deafness delimit what is acceptable for D/HH people to be or become. Medical discourses, driven by a rehabilitation model strive to normalise D/HH people by bringing them as close, functionally, to the hearing norm as assistive technology and therapy can allow. Social discourses, on the other hand, celebrate Deafness as entry into a cultural and linguistic minority group - the Deaf Community. It opposes the use of cochlear implants or rehabilitative strategies and concentrates instead on the use of Sign Language as the 'natural' language of Deaf people. While the dominance of one discourse over the other is both temporally and spatially contingent, in general, medical discourses wield more authority in the current system. This hegemonic trend towards medical

discourses of deafness is one of the main themes of this thesis and will be examined in detail in the following chapters.

While discourses are significant in power relations affecting D/HH people and those connected to them, material practices are also critical, with both the discursive and material complementing each other in determining a given outcome. In the case of a hegemonic medical model of deafness, a range of discursive and material practices are evident in the Irish context which, when combined, restrict the options available to parents in the decisions they make for their D/HH child. This is in line with Allen's (2003) interpretation of Foucauldian power as a narrowing of options.

As well as criticising the limitations of how power was theorised within geography, Allen (2003) also addresses the limitations to how modes of power were understood. Moving away from the conventional understanding of power, he proposes distinctions between power in its various guises. Table 4.1 below outlines the main modalities of power (Allen, J., 2003) visible in the deaf education system and provides examples how that power is reproduced through both discursive and material practices. These brief examples are for demonstration purposes only at this point, but will be elaborated upon in detail over the coming chapters.

Conventionally, power was thought of as domination, which in Weber's terms involved "the will of one party influencing 'that of the other even against the other's reluctance'" (Weber, 1978 in Allen, J., 2003: 27). It suggests a degree of imposition or constraint, is highly asymmetrical in nature, and can be achieved through close discipline, continuous control, and supervision (Allen, J., 2003). However, if domination is to be maintained across space and time, Allen (2003) argued that it must be "clothed in legitimacy", which he differentiates as authority. Unlike domination, authority suggests that there is a willingness to comply.

Once authority has been recognised, it does not have to be exercised with the same frequency; rather it is self-perpetuating through the compliance of those who recognise the authority of others. This is frequently the case with authority granted to institutional spaces, where the technical expertise of individuals is recognised by those they serve, who in turn comply with the guidance they are given, reflecting Foucault's concept of pastoral power. Authority allows for domination to continue

over space and time, extending institutional powers beyond the bricks and mortar of a given space to the everyday lives of those it affects. The reproduction of a medical model of deafness relies on such a tactic. While it was stressed above that power is not a capacity to be held by particular institutions, as Del Casino Jr. et al (2000: 526) highlight, institutions "are productive of certain meanings rather than others, and in this sense one can select them as candidates through which to view the operation of social power that limits what is thought, as well as a what is thought to be possible".

In addition, since the bureaucratic make-up of service provision prioritises the 'expertise' of certain individuals and institutions over others, their production of meanings is not only directing that which "is thought to be possible" but may also be practically influential since they control access to service provision. Subsequently, the authority of medical institutional views of deafness is hegemonic, not in that it cannot be resisted, but because resistance carries such negative consequences that individuals are disciplined into acceptance, even when they are opposed to the view it promotes. The starting point of reproducing the medical model of deafness therefore, is the authority both held in and bestowed to the field of medicine. An acknowledgement of this authority, however, does not suggest that there is no relational exchange in the construction and dismantling of that authority. On the contrary, this authority is in a constant state of negotiation which in turn involves various modes.

Table 4.1 Modalities of power (as domination) in the deaf education system.

Modality of power	Discursive	Deaf example	Material	Deaf example
Seduction A choice is presented, but a particular course of action is made more appealing.	Positive and negative discourses surrounding particular choices steer decision making by establishing social norms dictating what is appropriate or acceptable.	The concept that speech is a sign of success for D/HH children, where Sign Language is not.	Material services are provided to enhance a particular course of action.	Provision of numerous medical services to help promote spoken language acquisition.
Inducement A choice is presented, with one course made more appealing through incentives to steer decision making.	Making a particular decision is reinforced with positive discourses and approval, while negative discourses act as disincentives for choosing an alternative.	Parents encouraged into using speech over Sign Language through the approval of the medical authority for the former over the latter.	Improved service provision and access make a particular choice more appealing, or more feasible than the alternative.	Deaf parents with ideological objections to oralism enrolling their children in an oral school programme to gain access to improved educational services.
Coercion A choice is presented, but there is a threat of negative sanctions if a particular course is followed.	Eligibility criteria (either written or implied) for services dictate decision making by threatening access to services if particular course is followed.	Obtaining a guarantee as part criteria of eligibility for cochlear implantation that spoken language will be used	Access to services is threatened if a particular action is followed, thus steering decision-making.	Denying access to cochlear implantation or speech and language therapy services if parents use Sign Language.
Domination Ensuring the will of one against another.	Rules and regulations dictating a particular way of behaving.	Describing Sign Language as a sin to be confessed.	Surveillance, discipline and punishment used to enforce 'appropriate' behaviour.	Physical punishment for the use of Sign Language.
Authority The legitimacy to extend domination across space and time.	Granting particular knowledge(s) and individuals with legitimacy, both bureaucratic and social, at the expense of others.	Medical and educational professionals recognised as objective experts, while Deaf people are viewed as subjective non-experts.	Certain 'recognised' individuals granted the legitimacy to control access to services.	A psychologist's report can determine educational placement for D/HH children.

Allen lists various means of reproducing power relations (see Table 4.1 above). Citing Lipovetsky, Allen (2003) stresses that the central component of seduction is that the subject can opt out of a particular action through the presentation of choice, thus framing decisions as subject-made. He views it as a "modest form of power" at the opposite end of the spectrum to domination (Allen, J., 2003: 31). Negotiation and persuasion may be utilised if seduction is unsuccessful to further convince a subject to take a particular course of action. Inducement involves a small degree of force, usually through incentives whereby subjects are "won over" to a particular decision and subsequently "bring themselves into line"(Allen, J., 2003: 101). In manipulation, this degree of force becomes invisible as intent is concealed to ensure a desired outcome. Coercion, another conventional understanding of power threatens negative sanctions to ensure the subjugation of individuals. Chapter 7 will examine in detail how these various modes of power are manifested in the system of deaf education at present.

Modalities of Power as Resistance

In spite of the myriad forms of power as domination, there is also power to be found in the acts of those who refuse to be swayed by the various modes listed above. As such, there is also power in resistance. However, similar difficulties have existed with theories of resistance as those outlined by Allen (2003) in relation to domination:

Orthodox accounts of power, particularly as translated into the literatures of political and historical geography, tend to equate power straightforwardly with domination. Power thus becomes almost exclusively conceived of as the 'power to dominate' or as 'dominating power'. Similarly, orthodox accounts of resistance, particularly as translated into the literatures of social, cultural and development geography, tend to pit resistance against power or against domination (understood as a coherent oppressive force), or even to portray dominating power as so ubiquitous (as just so 'powerful') that acts of resistance appear either futile or trivial. In such accounts, moreover, matters are rarely conceived of in terms of the 'power to resist', what might be called 'resisting power' (Sharp, J.P. et al., 2000b: 2).

Sharp et al (2000) therefore note that resistance has frequently been pitted against domination as futile or trivial. They highlight that instead of pitting power and

resistance against each other, that it should instead be acknowledged that there is power in resistance, a resisting power.

This resisting power attempts to counteract the impositions of dominating power either through small or developed gestures. As Rose (2002: 383) states, these acts “strategically subvert, appropriate, and contest hegemonic spaces and the dominant relations they stand for”. Sharp et al (2000) examine what they view as orthodox accounts of resistance categorised across two broad theories of resistance:

- a) resource mobilisation theories
- b) identity-oriented theories.

The first examines the cooperation between groups with opposing interests as they collectively resist domination. These groups can work on either local-level social institutions in mobilising social movements, or focus on the influence that government and inter-governmental policies and power struggles have on strategies and tactics of social movements.

Identity oriented theory is interested in the formation of identities and solidarities which are then defended, as well as examining the impacts of social and cultural developments within society at large on social movements. This theory criticises the first (resource mobilisation theory) for

studying social movement strategies as if actors are defined by their goals [...and] that crucial to a fuller understanding of resistance are both the systems of political legitimacy that exist and the interplay between ideologies of domination and subordination (Sharp, J.P. et al., 2000b: 9).

Some work from within this identity-oriented theory include Touraine who argues that “social movements frame their struggles in terms of a cultural project, their aim being the control of historicity”, Laclau and Mouffe’s work on social movements “as a terrain of negotiations between hegemonic and counter-hegemonic interpretations and positions” and Melucci who argued that social movements act as messages, symbolic challenges to dominant codes (Sharp, J.P. et al., 2000b: 9). Sharp et al (2000) criticise both of these approaches however in that they continue to uphold the binary opposition between domination and resistance.

The same is true of non-violence theory, which views power as being dependent on the tractability (docility) of those being dominated, and is therefore inherent in all social and political relationships. Here, power is fragile and dependent on the cooperation, consent and obedience of subjects. Resistance occurs in a non violent fashion through non-compliance and disobedience, through “the withdrawal of consent, cooperation and obedience by subjects from those who purport to rule them” (Sharp, J.P. et al., 2000b: 10). The strategies of non-violent resistance are conversion, accommodation and non-violent coercion. While non-violent theory accepts a relational view of power, the binary opposition between domination and resistance is still evident.

Challenging this domination/resistance dichotomy, Valentine and Skelton (2003: 314), echoing Allen's work on domination, problematise the notion of resistance stating that it “conceals a diverse range of practices, degrees of intentionality, and reflexivity that might be more effectively differentiated”. Thus, resistance is not simply the opposite of domination. Since what was traditionally perceived as ‘domination’ involves, in reality, a diverse range of tactics, so too is resistance the combination of a variety of acts. These too are played out in both discursive and material practices. Table 4.2 below summarises power as resistance as it is played out in deaf education. Like Table 4.1 above, these examples are briefly mentioned but form the basis for chapter 8.

Indeed, when these ‘degrees of intentionality’ are differentiated, we realise that there are acts, whilst resisting in nature, may lack an intentional motivation to “strategically subvert” the system, and therefore run the risk of romanticising resistance (Cresswell, T., 1996). As such, there appears to be a distinction between intentional and unintentional forms of resistance (Rose, M., 2002). Those acts, unintentional in nature yet with a visible result that counteracts the intentions of the dominant group could instead be viewed as transgressions (Cresswell, T., 1996). As Rose highlights:

unintentional resistance encompasses acts that have subversive and potentially emancipatory effects but which are not conceptualised in terms of conscious ideological struggle... whereas the first form [intentional] of resistance is a direct response to

power, the second [transgression] is motivated by interests and desires that lie outside the purview of hegemony (2002: 385).

Table 4.2 Modalities of power (as resistance) in the deaf education system.

Modality of power	Discursive	Deaf example	Material	Deaf example
Non-consent Refusal to behave/think/act in a particular way	Refusing to subscribe to a particular ideology.	Deaf Community refusal of the term "hearing-impaired".	Refusing to follow a particular course of action	Deaf children's refusal to wear hearing aids.
Non-cooperation Refusal to support a particular way of behaving/thinking/acting.	Refusing to support or promote a particular (hegemonic) way of thinking	Parents of deaf children combining speech and Sign Language services, thus denying hegemonic discourses from both medical and social sides.	Refusing to support or promote a particular (hegemonic) course of action	Deaf people wearing hearing aids for environmental sounds only, and not for speech development.
Disobedience Acts deliberately contradicting established rules and regulations.	Deliberately opposing particular way of thinking.	Development of linguistic techniques in Sign Language, such as subtle facial expressions to denote that a teacher was approaching, thus facilitating continued use of Sign Language in spite of rules to the contrary.	Deliberately opposing a particular course of action	Residential students disobeying rules against the use of Sign Language.
Protest Organised, deliberate and strategic acts to oppose a particular ideology or practice, often held publicly with the intention of encouraging others to do likewise.	Deliberately and strategically opposing a particular way of thinking.	Deaf Community movement to standardise the use of the word Deaf over deaf, thus promoting a social understanding of Deafness.	Deliberately and strategically opposing a particular course of action.	Gallaudet University students during the 1986 Deaf President Now campaign barricaded their campus and marched on Capitol Hill to ensure the resignation of the recently appointed hearing president of the University.

For example, unintentional resistance could apply to the negative attitude among many D/HH children towards hearing-aids due to the physical discomfort involved, where their resistance is unintentional and not motivated by some force of domination from the outside. Instead, their desire to not use hearing-aids comes from within and is often an acutely physical and comfort based decision. However, this action is reinterpreted by the Deaf Community who then frames refusal to wear hearing-aids within a resistance discourse. Of course, when children become older, their decision to not wear hearing-aids may be categorised as a valid form of intentional resistance.

Even within intentional acts of resistance, there is a great degree of diversity in how these acts are manifested, from “organised and disruptive” to “independent and concealed” (Rose, M., 2002: 385). Rose (2002) is also quick to establish that being unintentional does not necessarily mean that these acts are accidental, but rather that they do not "directly oppose the perceived source of oppression" but are instead driven by other motives. Pragmatic acts of rule breaking such as stealing food during a famine would count as unintentional resistance.

While there has been a great degree in variation among authors as to what counts as resistance (see Rose, M., 2002), this thesis examines both intentional and unintentional acts, and views resistance, as Pile (1997 quoted in Rose, 2002: 386) did, as the desire to create "alternative spatialities [that] coexist within hegemonic space and engage its norms from various perspectives". Subsequently, a social model of Deafness, however it is articulated, within a system which promotes a hegemonic medical view of deafness, is examined as an act of resistance. Nonetheless, I am aware of Rose's (2002) criticism of Pile (1997) which is concerned with the overgeneralization of resistance, and echoes Cresswell's (1996) concern with romanticising resistance. Bearing this in mind, this thesis differentiates between conscious acts of resistance and subconscious acts of transgression. At times, it uses the term transgression/resistance, in particular in relation to parents' actions which are often pragmatic in nature as opposed to being grounded within an ideological struggle. They have, nonetheless the potential to develop into resistance. Thus, the term transgression/resistance highlights not only

the difficulty in identifying where one act ends and the other begins, but also the fluidity between both, as well as the ability of one to develop into the other across space and time.

Conclusion

This chapter outlined the various theories relating to power generally within the field of geography, and to the work of Foucault specifically. The conventional notion of power as domination was deconstructed, and power as a relational concept enacted both discursively and materially, in constant negotiation between various actors across space and time was put forward. Following on from this, the proceeding chapters will examine the mainstreaming of deaf education in Ireland through a Foucauldian lens. Specifically, it seeks to outline how a hegemonic medical discourse of deafness was established, is reproduced, and resisted across space and time.

This theorised approach to deaf education is in response to the largely atheoretical and highly empirical nature of contemporary research (see chapter 2). While there has been progress in situating the history of deaf education within a theoretical framework (Baynton, D.C., 1996; Branson, J. and Miller, D., 2002; Lane, H., 1976, 1989), the field has neglected to address the power dynamics of *contemporary* education processes, with the already mentioned exceptions of Komesaroff (2008) and Lane (1992). Such an approach is of even greater importance now given the dramatic shift in ideology surrounding deaf education in the wake of mainstreaming. As a result, the analysis on the current system of deaf education in Ireland which follows is deeply rooted in the theoretical concepts of power. What it means to be D/HH has undergone continuous change since the establishment of deaf education. These changing discourses are examined in the next chapter, which looks at the history of deaf education. However, the mainstreaming movement has seen a significant change in how these discourses are realised. This is because unlike the changes of the past, this shift is accompanied by a dramatic rearrangement of the geographies of deaf education. As a result, the practices of domination and resistance familiar to the field of deaf education are

evolving, with unforeseen circumstances for D/HH children, their families and the Deaf Community at large.

5 A History of Deaf Education: Establishing a Hegemonic Medical Discourse of Deafness.

The job of the educator is not to educate; it is to find an educational treatment for what the otologist and audiologist could not treat, the child's failure to acquire English normally. A difference has been identified; now a massive campaign begins to eradicate it. (Lane, H., 1992: 25)

Introduction

Systematic education organised via institutional spaces for D/HH children began in the late 18th century and flourished through the 19th-century. While these schools predominantly used Sign Language in instruction, by the beginning of the 20th-century Sign Language had almost completely disappeared in the instruction of D/HH students in schools across Europe and the United States. Teachers who were themselves D/HH and had been working alongside their hearing colleagues for over a century became redundant in the deaf education system. 'Hearing impairment' became a target in eugenics policy with D/HH people being classified as feeble-minded, undergoing compulsory sterilisation, and eventually being systematically 'euthanised' under the Nazi regime (Biesold, H., 1999).

In early 20th century Ireland however, deaf education was still primarily a manual system with Sign Language being used in the larger schools for the deaf in Dublin. Furthermore, D/HH teachers, though not quite equal to their hearing colleagues, were still valued members of staff in those schools. The Irish system at that time was quite unique in the Western context. Nonetheless, there has been scant examination of the reasons for this uniqueness and why, in the face of changes across Europe and the United States, Ireland maintained its use of Sign Language until the 1950s. This chapter goes some way to address this lacuna as well as a more generalised absence of theoretical historical contextualisation in research on contemporary deaf education systems. In particular, it wishes to build on a Foucauldian analysis on the origins of a hegemonic medical model of deafness in deaf education, which has been well documented in international literature, by shedding new light on this phenomenon in the Irish context. It will focus on two

international events to illustrate this phenomenon: the entry of the physician into the system of deaf education, and the subsequent change from a manual education system to one focusing on aural rehabilitation and speech training. It will also address the modes and techniques of power used in greater detail than has typically been the case in such analyses.

While the historical context surrounding these events was addressed by Branson and Miller (2002) in relation to the British system, and the French and American systems have also been well documented (Baynton, D.C., 1996; Lane, H., 1989; van Cleve, J.V. and Crouch, B.A., 1989; Winefield, R., 1987) such theoretical positioning has been rare in the Irish context²⁴ where instead histories of deaf education are largely biographical or descriptive in nature (Crean, E.J., 1997; Griffey, S.N., 1994; Pollard, R., 2006). Furthermore, while Branson and Miller (2002) take Foucault as their inspiration in conducting their 'sociological imagination' of deaf education, and his writings are echoed through the book in particular in their examination of 'the great confinement' and 'clinical gaze' of D/HH people, they refrain from making explicit connections between the specific techniques outlined by Foucault in the creation of subjects and how these might apply to D/HH people. Subsequently, this chapter hopes to add to the international literature by explicitly and critically connecting the techniques of discipline and modes of creating a subject outlined by Foucault to examine the development of deaf education.

In particular, this chapter focuses on changes that took place during the 18th and 19th century giving rise to a systematic discipline of deaf education which created subjects out of D/HH children. Due to the influence of the US and European school systems on the situation in Ireland, the international focus of this chapter will limit itself to those jurisdictions, in particular France, the US and the UK. By taking Foucault's "Birth of the Asylum" as an example, the history of deaf education will be traced from its anatomo-politic history to its biopolitic present. As deaf education developed (much like psychiatry as analysed by Foucault) the

²⁴ For a notable exception see McDonnell 2007. Though this work focuses on disability in general there is some reference to schools for the deaf.

element of control moved from the body of the D/HH person in its entirety, controlled through segregation practices to an internalised control of the mind by constructing a discourse of deafness to be rejected by D/HH people themselves. In carrying out this analysis, instead of concentrating on changing social conditions as others have done, the focus here is on the rise of a medicalised deaf education system by examining two main issues: the rise of the social authority of the doctor in educational matters, and the development of a negative discourse of Sign Language. This chapter focuses on the establishment of a hegemonic medical model of deafness creating a basis for the following chapters which look at how this model is reproduced in the current system of deaf education in Ireland (chapter 7), as well as how it is resisted (chapter 8).

Early Endeavours in Deaf Education

Since its focus is on the systematic education of D/HH students, this chapter will concentrate for the most part from the opening of the first state-funded school for D/HH children in the world, L'Institut National des Sourds Muets²⁵ (National Institute of Deaf-Mutes – hereafter referred to as the Institute) in Paris in 1760. Before that development took place, however, there were a number of small scale endeavours in educating D/HH people. These arose in the 17th century and were largely inspired by the desire for the religious salvation of D/HH people, who since “faith cometh by hearing, and hearing by the Word of God” (St Paul’s Epistle to the Romans chapter 10 verse 17) were at risk of damnation.

A number of developments specific to the 17th-century paved the way for the globalised establishment of systematic deaf education. Taking inspiration from Foucault, Branson and Miller (2002) cite the collapse of feudalism in the 15th century and the subsequent increase in State-control of the population, disestablishment of the church and the birth of science in the centuries that followed as instigators for the cultural construction of deafness as a disability. Of particular significance was the rise in scientific rationality, with the Royal Society, established in 1663 providing a forum for those working on scientific discovery. Rationalism

²⁵ Now called L'Institut National de Jeunes Sourds de Paris (INJS).

became the new god, and anti-rationalism, for example madness and unreason, became a new danger, leading to the great confinement (Foucault, M., 1965). Pursuit of order during this period led to classifying nature and establishing the fundamental division between human and nonhuman, of which language was to become a distinguishing characteristic (for discussion see Baynton, D.C., 1996). These social changes had a number of impacts on D/HH people.

D/HH people's perceived lack of language or use of an unconventional language (Sign Language) became a cause of great inquiry among philosophers of the 17th century. Trials at educating D/HH people became a common scientific and philosophical experiment. This can be seen through the prolific growth in publications regarding D/HH people which observed that hearing and speech were separate, meaning that D/HH people were capable of mental functioning in spite of their inability to speak, and outlining methods of educating D/HH people through the use of signs (van Cleeve & Crouch, 1989: 8). The publication of Juan Pablo Bonet's *The Reduction of Letters and the Art of Teaching the Mute to Speak* in 1620 contained illustrations of the manual alphabet initially recorded by Melchor de Yebra. It also documented the teaching methods employed by Pedro Ponce de Leon, a Spanish Benedictine monk who had written on his experiences of educating two congenitally deaf sons in the middle of the 16th century. The original writings by de Yebra and de Leon did not survive, but their achievements became renowned through Bonet's book. Furthermore, this publication among others allowed for the widespread distribution of teaching methods employed in Europe at the time. Subsequently, it is no coincidence that the manual alphabet used in France and ultimately the United States, Ireland, and much of Europe strongly resembles this initial publication, and that, in spite of those who went before him, Pedro Ponce de Leon is internationally accepted as the first teacher of the deaf.

As well as this growth in linguistic research, literacy gained new importance through the 17th-century and soon became a symbol of civilisation and progress through education. But it was a skill particularly difficult for those who were congenitally and pre-linguistically deaf to acquire, owing to its phonetic basis. Van Cleeve & Crouch note that:

deaf people may have fit easily and relatively comfortably into the illiterate rural life shared by most people throughout history, but in a new literate world they would be in serious difficulty – handicapped - without special education. Thus, it is not surprising that with the 17th-century, medical and theological musings over deafness give way to literature about the education of deaf people (1989:9).

These developments in the 17th-century gave way for individual attempts at educating D/HH students conducted largely by clergymen such as Bonet in Spain or philosophers interested in language development such as John Wilkins or Kenelm Digby in the UK (Branson, J. and Miller, D., 2002). It was throughout the 18th century however that the systematic education of D/HH children became widespread, and that the goal of education changed focus from a select group of wealthy individuals to the mass ‘salvation’ of D/HH people at large.

Deaf Education in the 18th Century: Creating Deaf Subjects

The previous chapter outlined Foucault’s theories on the creation of subjects and the three methods of objectification: dividing practices, scientific classification, and subjectification. I highlighted that there was a chronological aspect to movement from dividing practices through to subjectification. In this chapter, dividing practices and scientific classification as they relate to international deaf education will be dealt with in this section. The section on deaf education in Ireland will examine all three methods since they followed in quick succession.

The 18 century was a period greatly characterised by the arrival of institutional spaces of control for the perceived deviants of society, beginning with the poor, continuing with the sick, and eventually extending to all those categorised as having some form of (socially) pathological condition. Foucault refers to this as process of segregating and treating the deviants of society as ‘dividing practices’.

Dividing Practices: Establishing State Schools for the Deaf

The first of these, dividing practices, was a significant feature in the early establishment of education for D/HH children, with the large scale segregation (or congregation) of D/HH children. McDonnell (2007) highlights the important role

the establishment of poor houses and following that, early modern hospitals had in paving the way for charitable institutions (such as schools for D/HH children) catering for the needs of the 'unfit' of society. In particular, early modern hospitals provided an enclosed site for segregating these 'unfit' persons, though underlined by a rhetoric that it was for their own benefit. Furthermore, it allowed for the development and practice of a scientific, pathological medicine and provided an observatory for the collection of data and medical training, thus extending the authority afforded to medical practitioners beyond the hospital and into other institutional spaces (McDonnell, P., 2007). On foot of these developments, as well as those mentioned earlier from the 17th century and larger trends towards systematic education of young people, schools for the deaf were opened in abundance throughout Europe and the US during the 18th and early 19th century.

With the widespread delivery of deaf education, student demographics changed substantially. Originally limited to the children of nobility and upper-class families, and conducted in small one-to-one settings, education became accessible to the D/HH children of poor families. This change reflected a change in the driving force for deaf education at the time. Prior to the 18th century, the individualised education of D/HH children of wealthy families was a largely philosophical pursuit in an attempt to better understand the nature of the human mind. In the 18th century however, scientific rationalism and missionary zeal combined forces creating what Branson and Miller (2002) refer to as "moral therapy", echoing Foucault's analysis on the birth of the asylum. Similar to the work of Tuke with madness (Foucault, M., 1965), deafness became a source of moral danger (due to their inability to hear the gospel) and the widespread mass education of D/HH children during this period was subsequently instigated by the religious orders. The religious undertones of this movement were highlighted during the inaugural speech at the first commencement ceremony at the National College of Deaf Mutes (later to become Gallaudet College) in Washington, DC:

[[f]rom moral darkness, deeper even than that of heathen ignorance, wherein no proper idea of God or religion could germinate, to the full light of comprehended and accepted Christianity, stimulating the soul to the highest development possible in our world of

many clouds, and revealing the glorious hope of ripened fruitage under the rays of the Sun of Righteousness in the land of eternal day (Gallaudet, 1983: p.252).

While private entrepreneurs remained significant players in deaf education, the clergy took on a leading role in the establishment of schools across Europe and the United States. The world's first state-sponsored school for the deaf opened in Paris circa 1760, established by a Catholic clergyman Charles Michel Abée de l'Épée. This was soon followed by a school in Britain established by Thomas Braidwood, an entrepreneur rather than a clergyman, which was funded by the King from 1783 onwards (Branson, J. and Miller, D., 2002). Systematic education would not be established in the United States and Ireland until the beginning of the 19th-century, but again the clergy was to play a significant role in their development.

The rapid establishment of schools for the deaf in the US was largely a product of the French and UK systems. Through the beginning of the 19th century schools were established by Thomas Hopkins Gallaudet as well as British man John Braidwood (Thomas Braidwood's son). Due to the further reaching effects of Gallaudet's mission, I will focus on his efforts and not that of John Braidwood here. Gallaudet had travelled to Europe and returned with a deaf teacher from Épée's Institute in Paris, Laurent Clerc. Together they established the first school for the deaf in the United States in Hartford, Connecticut. By its second year, enrolment in the Hartford school had reached 115 pupils with only three teachers (Crean, 1997: 82). Teacher training began in 1818 to allow for the dispersal of schools beyond Connecticut and by 1843 there were schools in six more states, an expansion that continued through the coming decades (van Cleve, J.V. and Crouch, B.A., 1989). The rise in education nationwide led to the demand for further education possibilities for D/HH people and in 1864, the Columbia Institute for the Deaf and Dumb (later Gallaudet College and then Gallaudet University) was opened in Washington, DC with Edward Miner Gallaudet, Thomas Hopkins' son, as its first superintendent. In Ireland, the first school for the deaf was sponsored by the Protestant community of Dublin and the Catholic community followed suit a few decades later. The history of deaf education in Ireland will be discussed in further detail below, but suffice to

say here that the religious orders played as significant a role, if not more so, than in the establishment of deaf education elsewhere.

At the same time that education through Sign language was flourishing in the US, the home of the manual method – Epée’s Institute in Paris – was undergoing dramatic changes that would soon shift the emphasis away from manual instruction to a pure oral system. These changes largely came about due to the presence of a new figure in the Deaf Education field – the physician, and the coinciding rise in the social authority of medicine during this period.

Scientific Classification: The Social Authority of Medicine and the Rise of the Deaf Subject

The second method of objectification identified by Rabinow in Foucault’s creation of the subject is scientific classification. Foucault had noted that

starting in the eighteenth century human existence, human behaviour, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape (Foucault, M., 1977a: 135)

Under this movement, deafness became pathologised and medicalised in finely measured deviations from what was established as a hearing norm. In understanding this change in deaf education caused by the rise of the field of medicine, others (Branson, J. and Miller, D., 2002; McDonnell, P., 2007) have pointed to Foucault’s work on *The Politics of Health in the Eighteenth Century* (Foucault, M., 2002). Branson and Miller also draw on Foucault’s “Birth of the Clinic” summarising that “whereas medicine had, up to the end of the 18th century, focused on health rather than normality, 19th century medicine was concerned more with normality than health” (Branson, J. and Miller, D., 2002: 39). To this I would add his writings on social medicine (Foucault, M., 1977a) the treatment of mental illness (Foucault, M., 1965) and systems of discipline (Foucault, M., 1977b).

Foucault (1977a) traces the development of modern medicine from the 18th century onwards. Analysing the particular political, social and economic forces in place during the 18th and 19th centuries which led to the development of a systematic

form of health care across Europe, Foucault observes that the field of medicine was to emerge as a strong force in the identification and treatment of deviant bodies and notes that: "[t]he doctor becomes a great adviser and expert, if not in the art of governing at least in that of observing, correcting, and improving the social "body" and maintaining it in a permanent state of health" (Foucault, M., 1980: 100). He notes two transformations that take place during the 18th century as a result of rapid population growth and medicalisation family, thus facilitating the development of modern medicine. The first transformation is what he refers to as "the progressive dislocation of these mixed and polyvalent procedures of assistance" (Foucault, M., 1980: 93). In this move, the category of pauper becomes dismantled and concepts of poverty become replaced with those of idleness. Economic productivity becomes a significant discourse supporting the assistance/rehabilitation to those seen as being unproductive in society. As Foucault states

the problem is to set the "able-bodied" poor to work and transform them into a useful labour force; but it is also to assure the self-financing by the poor themselves of the cost of their sickness and temporary or permanent incapacitation, and further to make profitable in the short or long-term the education of orphans and foundlings (Foucault, M., 1980: 93)

His second observation is a more generalised attempt at instilling health and well-being as a political objective for the population in general. These factors combine to signal the arrival of social medicine during a period of population growth which also sees an increased interest in the body as "the bearer of new variables" (Foucault, M., 1980: 95) among which Foucault lists utilisation, profitability, and capacity for being usefully trained. Within this framework, the disabled body is problematised and must enter a system of rehabilitation and normalisation to improve its productivity, a measure which becomes a significant factor in interpreting the value and usefulness of bodies. The physician emerges as an expert in classifying bodies according to these new variables, and treating anomalies as they occur. Foucault states that medicine "assumes an increasingly important place in the administrative system and machinery of power, a role constantly widened and strengthened throughout the 18th century" (Foucault, M., 1980: 100). Symbols of this increasing power of the medical doctor include their

role in the production of encyclopaedias, membership in revolutionary assemblies, their presence in the academies, their role as counsellors to those in power, and the organisation of medical societies (Foucault, M., 1980: 100).

The medicalisation of D/HH bodies, and its subsequent entry into 'a machinery of power' began a little later, at the turn of the 19th century in France. Branson and Miller (2002) highlight that the ready availability of guillotined heads following the French Revolution at the end of the 18th century provided cadavers for medical research, giving rise to a more rapid development of knowledge in audiology in France than was happening elsewhere. These developments were accompanied by the entry of a physician into the Institute in Paris which was to dramatically influence the direction of deaf education for the coming centuries.

On the 31st of December 1800, Jean-Marc-Gaspard Itard began his post as resident physician at Epée's Institute in Paris, which was at that stage under the management of Abee Sicard. As we have already noted, prior to this appointment, the field of deaf education was largely pursued by the clergy (e.g. Epée) or private entrepreneurs (e.g. Braidwood), and medical professionals had not played a significant role in the industry. However, by the end of the 19th century this would have changed significantly and a pathological view of deafness would emerge as a hegemonic discourse. As Branson and Miller note:

[o]nce confined and displayed during the 17th and 18th centuries, they became the object of a new kind of display and of a new and more encompassing control in the 19th century. They were displayed to the clinical gaze and controlled not only physically but also to the very core of their being (2002: 40).

Ironically, Itard had been hired, not as a physician for D/HH children generally, but to take over the care and education of Victor, the *enfant sauvage* who had been found one year earlier in the forests of Aveyron and entrusted to the care of the Institute. During and after his five years of training with Victor, Itard transferred his attention to the D/HH students at the institute, making a number of discoveries about deafness which led significantly to the establishment of a systematic approach of assessment, classification, and oral instruction of D/HH

children, a realm that had been largely haphazard until this time. As Lane summarises:

[t]o Itard must go to credit for developing, largely independently, a systematic, principled program of oral training which would later be instituted in France and elaborated and modified by other teachers of the deaf throughout Europe and America (1976: 185).

The 'success' of Itard's work with D/HH children rested on a number of factors, which were later to become characteristic of the rise of the authority of the medical professional in the field of deaf education. These factors include; 1) the scale at which treatment of the D/HH child was targeted; 2) the selection of 'appropriate' candidates and provision of intense tutoring; 3) establishing speech instead of language as the goal of deaf education; 4) a meticulous and standardised medical approach to documenting and disseminating findings; and 5) mobilising the support of medical authorities who could lend weight to his method.

Regarding the first of these, Itard approached deaf education from the micro scale of the child's pathological ear. He therefore shifted the focus of education from the material to be learned to the child who was learning, and from the child *en masse* to the individual elements of their development, devising what we know today as individual education plans. He used his medical knowledge and his readings of Condillac's methods of analysis to survey D/HH children as what Foucault would later term 'docile bodies', a sort of *homme-machine*. As McDonnell highlights "[t]he clinical detachment and self-confidence with which Itard approached this task illustrates the extent to which the bodies of deaf pupils by the beginning of the 19th century, had been constituted as anomalous objects to be known, made docile, 'transformed and improved'. To progress his work, he began a number of case studies with D/HH children from the Institute.

Secondly, his selected students were tutored for two hours a day over the course of three years in an attempt to improve their sensitivity to the spoken word, and to encourage them to speak. This micro scale approach meant that very few students were involved in Itard's training, and that for those who were selected,

training was intensive, marking a move away from the mass education provided through Sign Language at the Institute.

Thirdly, Itard promoted speech as the new goal of deaf education and simultaneously established a negative discourse around Sign Language, depicting it as a 'barrier' to the 'normal' development of D/HH children. The intensity and length of listening and speaking work can be juxtaposed against the loss of hours these students experienced in accessing the general curriculum. In pursuing speech, Itard came to one of his most controversial recommendations: that better success could be achieved in oral training if students were isolated from Sign Language. Lane highlights that after only one year at the Institute and in spite of having no command of Sign Language, Itard remarked:

[we must] allow no means of communication other than spoken language between the hard-of-hearing child and the people who take care of him; failing this, the first means of training [by speaking loudly and slowly to the child] becomes ineffective; and the child, discouraged by the effort of attention he is obliged to put into speaking or listening, ends up by creating an action language or manual sounds, with which he expresses all his needs. Once this modality is discovered and tolerated, the ear loses the sensitivity, the larynx its mobility, and the child remains deaf-mute forever (*in* Lane, 1976: 204).

At this point, the production of speech becomes paramount in deaf education as viewed by Itard and Sign Language (inaccurately) becomes viewed as a great barrier to that goal. This would eventually lead to an atmosphere across the United States and Europe which was, in Baynton's terms, "not only favourable to speech but quite hostile to sign language" (1996: 25).

Fourthly, Itard's progress was consolidated by the fact that he recorded with meticulous detail his technique in assessment and treatment of his D/HH students, thus allowing for his technique to transcend space (by being administered at other institutions) and time (with his techniques continuing to be influential today). This brings to mind Allen's definition of authority as allowing domination to extend both spatially and temporally noting that "if the exercise of domination in the formal sense is to be maintained, it has to be clothed in legitimacy" (Allen, J., 2003: 29). While another French educator, Pereire had previously been quite successful in oral

education, he kept his system a closely guarded secret. In contrast, Itard's speech instruction was meticulously detailed progressing from simple vowels to more complex vowel-consonant combinations. His minute attention to detail in his technique echoes what Foucault refers to as the creation of docile bodies, where

no detail is unimportant, but not so much for the meaning that it conceals within it as for the hold it provides for the power that wishes to seize it... the mystique of the everyday is joined here with the discipline of the minute (Foucault, M., 1977c: 184).

Finally, it is unlikely that Itard's recommendations to abandon Sign Language would have carried great weight in a school which saw such value in the manual method, indeed there is much evidence of their opposition to oralism (Lane, H., 1976). Thus, Itard implemented what was to become his 'trump card' in the running of the Institute: he used the backing of the medical authorities, an authority which superseded that of the educational expertise held by teachers, to sway government opinion regarding the goal of the Institute. Itard disseminated his results and opinions on Sign Language through the pre-established and organised network of scientific medicine. Itard's findings became well-known among the medical professionals of Paris gaining him notoriety and respect among his medical peers, an asset that would stand to him when he instigated changes within the Institute. In 1808, when he presented his most successful articulation student to the Society of the Faculty of Medicine, they concurred with his recommendation stating that "the development of speech will be more prompt and more complete the less the subject is able to use manual sign language" (Lane, H., 1976: 204). Thus the medical pursuit of speech for D/HH children began in earnest.

The dubious circumstances surrounding the change to oralism which occurred during Itard's era point to the successful use of authority as a strategy of ensuring domination. The move to oralism occurred in spite of the fact that Itard's 'evidence' was based on the exhibition of a single student, who had been carefully selected and underwent intensive training. As a result, this student's experience did not represent the vast majority of students at the Institute. Adding to that the fact that Itard had no level of expertise in Sign Language upon which to base his

recommendations, and that the staff of the school themselves greatly objected to this move, it is safe to conclude that significant weight was given to the authority he could draw upon as a physician during this period. As a result, during Itard's time in the Institute and with the work of those physicians who succeeded him, Epée's manual school was soon to become an oral-only establishment, using a method which would soon spread across Europe and the United States. Indeed, Itard was the first physician in the history of deaf education to successfully utilise the social authority of medicine to secure changes to the deaf education system, a strategy which has featured frequently since then. Drawing on Allen's understanding of authority (see chapter 4) as the legitimacy to extend domination across space and time, the example of Itard shows us how the figure of the physician has become synonymous with educational expert allowing for a hegemonic medical model of deafness to pervade the education system, instigated in early 19th century Paris and reproduced over time and space since then.

The International Rise of Oralism

This international change to oralism during the late 19th century is often anecdotally cited as a result of a congress which took place in Milan in 1880 where the decision was made that oralism would become the sole methodology of deaf education²⁶. However, this has become somewhat of a legend in Deaf folklore. While the conference did take place, and the decisions made there undoubtedly had an impact on the diffusion of oralism, there was a complex combination of sociopolitical factors at play, not to mention Itard's contribution highlighted above, during this period which meant that speech, and not signs, were seen as the way forward for D/HH children. As Branson and Miller highlight oralism arose out of:

the interweaving of industrialisation, imperialism, the rapid rise, and professionalisation... of a group of thoroughly socialised individuals who were middle-class and who maintained an imperial orientation [and] they were reinterpreting the goals and purpose of deaf education (2002: 43).

²⁶ At the opening of the 2010 International Congress on the Education of the Deaf a letter was read rejecting this decision at their 1880 congress.

Itard's work had its significance, but it was the sociopolitical context of the 19th and 20th centuries and the factors highlighted by Branson and Miller above which meant that Sign Language was soon to be viewed as an inappropriate means of educating D/HH people on an international scale. Branson and Miller highlight colonialism, Darwinism, and the increased bureaucratization of the education system through the 19th century as significant factors in the widespread adoption of Oralist policies in deaf education. The colonial agenda had, through its fascination with the exotic, drawn a newfound emphasis on differentiating the 'civilised' from the 'barbaric'. In this regard, it was responsible for linking Sign Languages to the so-called barbaric, uncivilised populations from the colonies. As a result, what Itard had established as a medicalised and pathologised view on deafness at the beginning of the 19th century was rapidly evolving into a social construction of deaf people as disabled, and therefore 'subhuman' (Branson, J. and Miller, D., 2002).

Simultaneously, increased emigration to the United States fuelled xenophobia and sparked fears of a pluralist, multicultural society. Ethnic minority groups were living together, establishing their own clubs and schools, and speaking their own languages. They were not, it was feared, assimilating with the Anglo-American community. There was a desire for a monolingual, monocultural Anglo-American United States, an English-speaking colony that would remain culturally familiar to British settlers. Multiculturalism threatened this. The Deaf Community, with its own language, schools, publications, clubs, and so forth, became identified as part of this threatening community. The goal became to assimilate these minority peoples with the majority culture through a monolingual education system.

This period was also characterised by a new-found fascination with evolution based on Darwin's *Origin of the Species* which was published in 1859 and became a best-seller. Darwinian theories came to symbolise not only "the supremacy [...] of contemporary humanity with the past forms but also of certain contemporary humans over other contemporary humans" (Branson, J. and Miller, D., 2002: 26). Where Colonialism and xenophobia had established the perceived superiority of some groups over others, evolutionary theory was implemented to justify this belief giving it a scientific basis. Evolution to human status was characterised by the

ability to speak and as a result, Sign Language was no longer seen as a viable means of educating deaf people. To speak was to be human, to sign was primitive and subhuman.

Bureaucracy also played an increasing role in the categorisation of disability due to the increased social complexity caused by industrialisation and imperialism (Branson, J. and Miller, D., 2002: 42). The move from feudalism to an urbanised State government population led to the need for a rational administrative process to ensure access to services for the population (Branson, J. and Miller, D., 2002). Furthermore, compulsory schooling became enacted in the UK by the *Education Act* of 1870 followed by the standardisation of teaching qualifications and uniform curricula. This also led to the testing of students to identify aptitudes and weaknesses in their learning. All of these factors combined signalled the beginning of an age of "overt linguistic imperialism with respect to the education of linguistic minorities" which was fuelled not only by this increase in bureaucracy but also by growth in immigration and xenophobia (Branson, J. and Miller, D., 2002: 43).

Overall, this was a period characterised by the fact that pathologies threatened the superiority of the middle class imperialist, a threat which was overcome by treating those who were viewed to have pathological conditions through medical intervention or through special education. These factors eventually transformed in the beginning of the 20th century to give rise to eugenics which would have devastating impacts on the Deaf Community. Eugenics rose throughout Europe and the US during this period with eugenicist journals and societies rapidly established in Germany (1904/1905), the US (1923), the UK (1928). The Eugenics movement was divided into those who promoted positive eugenics, concentrating efforts on promoting 'good breeding' practices, and negative eugenics which aimed to curb 'bad breeding'.

In the US, Alexander Graham Bell's positive eugenics argued that education had great potential in bolstering the superiority of a particular class, though he also had concerns about the inter-marriage of D/HH people and made moves to discourage D/HH couples from procreating. However, special education was criticised by the negative eugenicists who felt that it was a waste of time trying to

remedy disability through education. In “The Right to Be Born Well”, Stokes highlighted that

[i]n breeding horses, we render impotent to the unfit. We never try to render fit a sire by education. We have no sanatoriums for weak horses, to keep them alive at public expense, and then turned them loose to reproduce their unfitness, to refill more homes for defectives. The same rule should apply to humans (Stokes, 1917 quoted in Branson, J. and Miller, D., 2002: 30).

Such negative eugenics developed to the extreme under the Nazi regime in Germany, where those who were D/HH were first sterilised to prevent procreation, but this soon developed into widespread extermination as D/HH people were not seen to be ‘fit’ to live. Such a rise in the biopower of doctors was epitomised by the fact that doctors were given the right to decide life over death, the ultimate victory for science.

While Sign Language, D/HH teachers and eventually D/HH people themselves came under increasing threat across the US and Western Europe during the early twentieth century, the main deaf schools in Ireland still used Sign Language, employed D/HH teachers and had continuing supports for D/HH people through their adult lives. Ireland’s conversion to oralism did eventually transpire, though it was not until the middle of the 20th century. The changes above from a manual system to an oralist one described above took place in the US and much of Western Europe over the course of a century, under the influence of a wide range of social factors. With a rationale to scaffold oralism and medical and educational establishments lending their support to that system on an international level already in place, when it came time for Ireland to move from manualism to oralism, the move was much more rapid than happened elsewhere. As such, the three stages of creating a deaf subject can be seen in rapid, and at times simultaneous development in the Irish context.

Origins of Deaf Education in Ireland

In her account of deaf education in Ireland, Pollard (2006) notes that while there were some attempts at catering for D/HH children prior to the 1800s, it was

conducted mostly through industrial schools, asylums, and penitentiaries. For example, in 1816, when formal education for D/HH children was established in Ireland, there were 21 D/HH individuals in the House of Industry (Pollard, 2006: 59). It is also known that others travelled for their education to England. The first endeavour in providing an educational environment specifically for D/HH children was the 1816 opening of The Claremont Institute by Dr Charles Edward Herbert Orpen.

Orpen is an interesting character since he bridges the gap between the 18th century trend of deaf education founded in a religious ideology and the 19th-century pursuit of the medicalised deaf education system. While Orpen received his medical and surgical training in Edinburgh and London, he had initially intended to take holy orders, and was the son of a Protestant clergyman. He became interested in the area of deaf education when he read a report on the Institution for the Deaf and Dumb in Birmingham. After reading the report, he concluded:

so ignorant was I as to the wretched state of the deaf-mute when uneducated, and the importance and interesting nature of their instruction, that I took so little interest about them as not to visit the school in Birmingham at that time. On looking into the report, however, I found it had originated from a few lectures on the subject, and the exhibition of a little girl, whom Dr de Lys and his friend, Alexander Blair, had partially educated for the purpose. I know that no such school had ever existed in Ireland; and it occurred to me, that I might perhaps, at some future time, be able to apply the same means to this same end, for the good of my own country (Orpen quoted in Pollard, R., 2006: 15).

On returning to Ireland, he began to pursue the issue in earnest, following de Lys's model above.

Typical of scientific rationality of the time, and following in Itard's footsteps, Orpen's progress utilised his social authority as a physician and focused on the complete study of one individual. One Thomas Collins was selected from a group of children chosen from the Foundling Hospital and the Bedford Asylum for Orphans and used as a case study to garner public support for the need for an education system for the deaf across Ireland. Thomas spent three months under Dr Orpen's care and was taught skills in writing, mathematics and articulation. He featured in Dr Orpen's lectures at the Rotunda Assembly Rooms in Dublin, and was used as an exhibit for medical audiences. His lectures in Dublin and a later series

across the country brought a great deal of interest, and funds were gathered by the Protestant Archbishops to open a school in Dublin which would eventually be housed in Claremont, Glasnevin.

The religious sponsorship of the school was typical of education in Ireland at the time, and although Orpen was a medical doctor, he approached deaf education from the salvation model. In 1827, he published a book on his findings entitled *The Contrast, between Atheism, Paganism and Christianity, illustrated; or the Uneducated Deaf and Dumb, as Heathens, compared with those, Who Have Been Instructed in Language and Revelation, and taught by the Holy Spirit, as Christians*. The title underlines the significance that religion had to play in the Irish context even within this medical setting. With this religious goal in mind however, and considering the divisive nature of religious politics in Ireland at the time, it would not be long before a Catholic counterpart to the Protestant school in Claremont would be opened. Indeed, religious segregation in schools for D/HH children was to become a characteristic feature of deaf education in Ireland over the coming century.

Claremont was the first of several educational establishments for D/HH children in Ireland around this time. In 1822, a day school was opened in Cork by Dr Kehoe (a Roman Catholic) followed by a day school in 1824 in Dublin. In 1825, a new establishment, the Private Seminary for Respectable Deaf and Dumb Children was opened by Charles Devine. Of the three establishments based in the Dublin area, it seems that the Claremont Institute was the only one that had provisions to admit children of poorer Catholic families. Throughout this period, there was no state aid for deaf education and the survival of schools depended on voluntary contributions and charitable donations. While there was a tuition fee for each student, many of those attending Claremont could not afford these fees and were sponsored by various charities. While Claremont was funded by the Protestant community, it always had a majority Catholic enrolment. However, this primacy of the Protestant community in the provision of deaf education was short lived.

The Very Reverend Thomas McNamara, C.M instigated the search for funds to open a Catholic school for D/HH children in Dublin. As a result, in 1845 the Catholic Institute for the Deaf and Dumb (CIDD) was founded and St. Mary's

School for Deaf Girls (1846) and St. Joseph's School for Deaf Boys (1857) were opened in Cabra, Dublin. The establishment of the Cabra schools led to the demise of most other schools for D/HH children around the country, suggesting that the majority of those enrolled in earlier schools were Roman Catholic. Pollard has documented that a great deal of proselytising took place between the schools during this period, and the local action of Roman Catholic priests in rural parishes could dictate the educational placement of D/HH children living in their area, with frequent references to children being prevented from enrolling at Claremont through "the interference of the priest" (Pollard, R., 2006: 186). While the Claremont Institute survived the opening of the new schools, its enrolment was badly hit, thus beginning the monopoly of the Cabra institutes.

Like much of the educational system in Ireland of the era, the CIDD operated with the voluntary service of Catholic Clergy. St. Mary's was operated by the Dominican Sisters and St. Joseph's by the Christian Brothers. As a Catholic run school, the nuns of St. Mary's learned their methods, not from the nearby Claremont School, nor from the renowned Protestant Braidwood family in England, but from French Catholic schools in Le Bon Sauveur, Caen. Subsequently their method was similar to that employed by de l'Épée in Paris, and Gallaudet in the United States and was primarily manual. Crean (1997) argues that their opting for this French manual method and not the British oral method reflected the culture of the period, openly trusting anything representing the singularity of Catholicism and rejecting all else. Ireland was like much of Europe in that the early development of systematic education for D/HH children was largely manual and not oral, but 100 years after its establishment the Cabra schools were also on the path to converting their methodology to one which favoured speech over sign.

Early Methods of Deaf Education in Ireland

Deaf education was established in Ireland at a time when great debate was taking place in both England and on mainland Europe regarding educational methodology for D/HH children (see discussion above). The methods employed at the various schools in Ireland at the time seemed to represent the complexity and fluidity of the

contemporary situation. Orpen's initial letters prior to the establishment of the Claremont school states that Thomas Collins could count orally to 100. However, there is also documentation that Orpen was used as an 'interpreter' for his students and that the students in Claremont used Sign Language with each other (Pollard, R., 2006). Similarly, Joseph Humphries, the first superintendent of Claremont, used Sign Language. Since his training had been conducted in Edinburgh, he used the two-handed manual alphabet (similar to today's British Sign Language). This alphabet continued to be used in Claremont, however, the later Catholic schools for D/HH children adapted the French one-handed alphabet from 1845 on, leading to different sign systems in both schools. Furthermore, the Sign Language used in the two Cabra schools differed owing to the isolation of the religious orders from each other and the fact that the Christian brothers introduced a number of American signs to the system they used in the boys school.

Whatever system was used in the early days of Claremont, it is clear that by the 1840s that system had been replaced. James Cook, who began his role as headmaster in 1843, criticised the use of signs over finger spelling and proposed banishing signs altogether (Pollard, R., 2006: 75), likely influenced by trends across the UK during the period. In 1847, Cook resigned and was succeeded by James Foulston who appeared to be unsatisfied with the performance of the D/HH teaching assistants at the time. In spite of the fact that many of them had been there since Humphries era, he instigated having them removed. However, when Foulston's own methods were assessed in 1852 the committee found that between Foulston and his three hearing female teachers, there were two different sets of Sign Language being used, much to the confusion of the students. Foulston resigned in 1855 and was replaced by Mr Edward James Chidley, who appears to have had a definite method for educating the deaf.

In spite of the fact that he had been an instructor in the London institution, a school that employed the oral method, E.J. Chidley was against 'pure' oralism, and against the combined system. Furthermore, he was "baffled about a rigid rejection of sign language by some instructors of the deaf" (Pollard, R., 2006: 91). It is also evident that E.J. Chidley had great faith in his D/HH staff. During his time at

Claremont, Benjamin Payne and Samuel Johnson became noted D/HH teachers and each went on to distinguished positions in other institutes following their resignation from Claremont. Most unfortunate for the D/HH of that era, Edward James Chidley died suddenly on the 17th of February 1881. His son, Edward William Chidley succeeded his father and decided to introduce oral education. It can be assumed that Edward William was aware of the debate of Milan, 1880 and the simultaneous widespread implementation of oralism and the almost complete eradication of Sign Language in schools throughout Europe and the United States and there is evidence that he visited an oral school for the deaf in Paris which was "converted ... under circumstances similar to those of Claremont" (Pollard, R., 2006: 92). Whatever those circumstances, Claremont remained an oral school until its closure in 1978.

Cabra's Change to Oralism

The following account of the change to oralism within the Cabra schools is a decidedly Catholic-centric view of the deaf education system. As noted above, the Claremont School for Protestant children had changed to oralism at the end of the 19th century, following trends across Europe and the United States (Pollard, R., 2006). However, since the population of that school is so small in contrast to the Cabra schools, the impact of oralism there was not felt across the country. As well as that, the current system of deaf education in Ireland has been more strongly influenced by the changes taking place in Cabra, since individuals working in those schools went on to positions of influence, including teacher training, policy writing, and membership on government committees. Subsequently, this account will focus on the change as it occurred in the Cabra schools.

It was the Dominican nuns teaching in St Mary's School for Deaf Girls (hereafter referred to as St Mary's) in Cabra, Dublin who paved the way for the change to oralism in the Irish deaf education system during the 1950s. Since St Mary's made the move before the Christian Brother's school for the boys, and since the documentation on that move is more plentiful than that in St. Joseph's, the situation in the girls' school will be recounted here at the expense of the other. Indeed, the Dominican sisters had established their leadership status in deaf

education 100 years previously when it was they, and not the Christian brothers, who established the first school for D/HH children under the CIDD. Since the Christian Brother's frequently sought the advice of the Dominican Sisters in their educational endeavours (Crean, E.J., 1997), we can assume that their path into oralism was somewhat similar.

The change to Oralism at St Mary's school during the 1950s was particularly significant considering it was a school that had, for over 100 years and with great international acclaim promoted the education of D/HH girls through Sign Language. There has been some speculation as to the reason for Cabra's change to Oralism of the 1950s (Crean, E.J., 1997) yet surprisingly little investigation into the documented evidence such as minutes from meetings surrounding the period²⁷. While it has been argued the isolation of the religious orders preserved the manual method for so long in the Cabra schools (Crean, E.J., 1997), St. Mary's had in fact experimented with the oralist philosophy in the early 1900s but maintained a manualist system overall (Grehan, C., 2008). This suggests that they were, at least to some degree, aware of the international shift in methodology occurring both to the east in the UK and mainland Europe and to the West in the United States, as well of course as in the Protestant school in Claremont, Glasnevin a number of miles away. Others have pointed to financial restrictions up to the 1950s which prevented the change to Oralism (see Leeson, 2007 for discussion).

I would argue however, that it is more likely that a change in the leadership within the school was a major instigating factor. In the late 1940s, positions of both the principal of St Mary's school (1944) and the Prioress of the adjoining Dominican Convent (1945) were changed. At the time, the school had no formal relationship with the Department of Education and so was free to follow whatever methodology it saw fit. Sr Nicholas Griffey took up the position of principal, and Sr Peter Flynn the position of Prioress. Sr Peter Flynn, in particular became a significant force in

²⁷ My attention was drawn to the existence of these minutes towards the end of my writing up of the results and I endeavoured to get access. However, it coincided with the summer holiday period and I was unable to reach an agreement with the Catholic Institute for Deaf People in time. This would be a worthwhile avenue for research in the future.

the change to Oralism. She had a background in education, having been principal at St Mary's College of Education in Stranmillis in Belfast for almost a decade, and was familiar with the field of deaf education since her sister had taught at St Mary's in Cabra.

At the beginning of her post, she immediately changed the name of the school, indicating that her leadership was to bring a period of change to St Mary's. The change of name involved two significant moves, the dropping of the word "institution" to be replaced by school, and losing the word "dumb" entirely. Positioning St Mary's as an educational establishment as opposed to an institutional one was perhaps a reflection on the changing social conditions of the time, as well as Sr Peter Flynn's personal education background. Furthermore, eliminating the word "dumb" may also have been sensitive to social changes of the time, but marked a significant move away from the concept that D/HH children could not speak. It seems that from the outset, Sr Peter represented a changing ideology in how deaf education would be approached in St Mary's. It was she who instructed Sr Nicholas to undertake a course in the oral method in Manchester, UK. While it cannot be certain, it is quite possible that Sister Peter Flynn's role as principal in Stranmillis, Belfast meant that she was more familiar with the UK system, and in particular the work of the Ewing family, famous oral educators in Manchester. The relationship with the Ewings was to become a significant factor in deciding on strategies used to implement Oralism.

In her account of the change, Sr Nicholas Griffey notes that she began examining international trends in deaf education from 1945, stating "I had become too secure in the system used in the school. To me, the educational attainment of pupils leaving the school was quite satisfactory" (Griffey, S.N., 1994: 35). However, she cites the difficulty their past pupils reported in integrating with the hearing community on leaving school, the disadvantage they felt compared to their English counterparts at not been able to lip-read, the stigma associated with using Irish Sign Language, developments in the field of audiology, and shifting public opinion in Ireland as well as the wishes of parents pointing to the spread of oralism

across the rest of Europe, as contributing factors to the change in methodology in St Mary's (Griffey, S.N., 1994).

First and foremost, Sr Nicholas points to the obligation she felt to respond to the wishes of parents who, when they could afford it, were choosing to send their children to school in England to avail of the oralist system. Underlying this desire to fulfil parents' wishes was the fact that the Catholic hierarchy were concerned over the movement of Catholic children from Ireland to Protestant schools in England for education (Flynn, S.P., 1946). Indeed, in Sr Peter Flynn's report following their visits to the schools in England and Scotland in 1946, the opening paragraph reflects entirely on the movement of Irish Catholic children to schools in the UK, and laments in particular the presence of "many Irish Catholic children in the London Protestant Schools" (Flynn, S.P., 1946: 155). Similar to the establishment of the Catholic Institute for the Deaf and Dumb in the middle of the 19th century, the change to oralism in the middle of the 20th-century was to facilitate Catholic children with a *Catholic* education in their own country. On their return, Sr Nicholas and Sr Peter concluded that an oralist system was needed in Cabra, a conclusion based largely on a new-found medical perspective on deafness and not one necessarily adhering to either educational or social goals for the students. Indeed, in her report Sr Peter notes:

[f]rom what we have observed in the schools visited, we are obliged to confess that, while our general education, our training in religion, our school buildings and general conditions are superior to any school we have seen, we have failed to make use of the degree of hearing of children who are partially deaf, and who are capable of being educated by lip-reading and speech.... we think it's vital, however, that it should be known at once that children in St Mary's will in the future be trained in the oral method, if they are capable. *This is necessary if we are to stop the flow of Irish children to deaf schools in England and Scotland, who go there in search of the oral method* (Flynn, S.P., 1946: 157 my emphasis).

The change was justified with the Catholic hierarchy by arguing the need to keep Irish Catholic children in Irish Catholic schools and was justified to the public, teachers, and parents through a series of talks from 'experts' (Griffey, S.N., 1994). Thus Allen's concept of authority is echoed here in that of the 'expert voice', as one of the first steps in implementing oralism in the schools. Authoritative 'experts'

were to become an important tool in justifying and extending the oralist system in the school over the coming decades, with several site visits from teachers of schools in the UK, in particular the Ewings, as well as teachers from both France and Belgium. Having established a rationale and justification for oralism, the first practical move in implementation was one of segregation.

Dividing Practices and Scientific Classification: Instigating Oralism

The concept of dividing practices and scientific classification as it occurred in the international development of deaf education has been covered above. However, a number of changes to these methods were implemented in the oral context. D/HH children were segregated from their hearing peers throughout the 18th and 19th centuries for education, but the oral system saw more minute practices of segregation of deaf students from their *deaf* peers, with those using Sign Language separated from new students entering the school who had not been exposed to Sign Language. This segregation happened in stages in St. Mary's progressing in severity with time, and reflects the convergence of methods of turning D/HH children into subjects.

On Sister Nicholas and Sister Peter's return from their tour of England and Scotland in 1946, segregating those students who were partially deaf from those who were profoundly deaf became a priority in the school. This form of categorisation introduced an overt medicalisation of the students enrolled there, which had hitherto been absent. This segregation process began with testing all students' hearing levels to facilitate appropriate placement. However, this form of scientific classification was new to the school in Cabra and funding was necessary to purchase the audiology equipment necessary to test and categorise students, so an audiology clinic was opened in the school in 1947. This clinic is still in operation today and was cited by many of the parents involved in this research as the location where they received their eventual diagnosis.

During this initial phase of oralism, pupils already enrolled in the school were taught using a mixture of signs, speech and lip-reading, while those newly admitted students were taught with an oral method only (Griffey, S.N., 1994). However, after

a number of years Sister Nicholas concluded that the school was still a manual one. In particular, she observed that students in the oral programme mixed with those taught manually during their free time and that it was “obvious that all pupils were more interested in manual communication than in speech” (1994: 43). Their segregation strategies were not, it appeared, stringent enough. Following a visit to Le Bon Sauveur school in Caens in 1951 (where the Dominican sisters had first travelled 100 years previous), they concluded that complete separation of those students who used Sign Language from those on the oral programme was necessary. The advice of the Caen Sisters was:

[y]ou are wasting your time, you must separated the oral and the manual pupils. Find a building where the oral pupils will have no contact with those who are using signs. Separate! Separate! This is how we developed an oral atmosphere in the school (in Griffey, S.N., 1994: 47).

As a result, students continuing to use Sign Language were housed separately from those on the oral programme in a new wing on the top floor of St. Mary’s school, which was called St. Pius’ School. Later, in the 1960s, plans were made so the oral programme would be further divided in two: a programme for partially deaf students (Rosary School) and one for profoundly deaf students (St Mary's). The students were to be housed in separate sections of the school building, with different uniforms for each. While planning permission was sought to build a completely separate school for partially deaf students this was not established until the 1970s. As a result, students attending Rosary School and St Pius were both located on the same floor, though separated by a long corridor. To ensure that these students did not mix, spatial segregation was accompanied by temporal segregation which meant that common areas such as the playground or corridors were only inhabited by a particular group at each time, thus preventing students from seeing or communicating with each other (Grehan, C., 2008).

The use of different uniforms helped teachers in monitoring this segregation as it distinguished between categories of students enabling teachers to quickly identify individual students and the communication stream within which they were placed, as well as their age group. Grehan (2008) describes the six different uniforms she wore

as a profoundly deaf student going through St. Mary's school, showing the use of small changes in uniform between age groups as a means of identifying students. Furthermore, those students in St Pius wing had their hair cropped short (discussed below). Another important feature both supporting and being supported by the segregation of students was a number of restrictions around the use of Sign Language, which was to become increasingly significant in the future of deaf education in Ireland. The use of spatial segregation, timetabling, and uniforms shows the micro level of governance these D/HH girls were subject to, echoing again Foucault's concept of docile bodies.

Subjectification: A Negative Discourse of Sign Language

It is evident that, similar to developments in Europe and the United States in the century before, Sign Language became devalued during the change to oralism in Ireland, a factor that applied not only to students but also to teachers. There is evidence that D/HH teachers as well as hearing teachers who were able to sign were let go during this period (Grehan, C., 2008). In examining the devaluing of Sign Language, McDonnell and Saunders (1993) refer to internal and external strategies used to enforce speech over signing.

Internal strategies were focused on activities within the school and were directed at pupils. They consisted of controlling and disciplining strategies to try to minimise the use of Sign Language within the school through surveillance and punishment. For example, older students were encouraged to report on younger students for signing, and students were instructed to be vigilant with their movements, with strategies such as holding their hands behind their back or sitting on their hands practiced to discourage them from signing (McDonnell, P. and Saunders, H., 1993).

Not content that these strategies would deter students from using manual communication if left to their own devices, a second set of strategies creating a negative discourse of Sign Language was implemented. McDonnell and Saunders (1993) highlight that this tackled the values and belief systems of the students, instilling a sense of shame and inferiority in those who used Sign Language. It

extended control over student behaviour to those spaces and times where they were not supervised directly. This negative discourse of Sign Language represents the move to subjectification. It represents the move away from an anatomo-political control of D/HH bodies to a bio-political control by moving the focus of attention from the external control of an exterior body (through surveillance and punishment) to an internalised control of the mind (through the creation of a negative discourse of deafness that D/HH people will themselves come to reject). By internalising discipline, power over D/HH people becomes self-perpetuating, or in Allen's (2003) terms, imminent.

The very existence of a separate school for those students incapable of learning speech was the first step in establishing this negative discourse, by both socially and spatially isolating those students using Sign Language. Those students who failed within the oral system were socially isolated by being categorised as 'oral failures' and labelled 'deaf and dumb' (in spite of the fact that the term 'dumb' had been removed from the school name), and spatially isolated in the St. Pius wing. Furthermore, students were explicitly told that Sign Language was aligned with "being stupid" and that it would prevent them from learning speech specifically, as well as from learning in general (McDonnell, P. and Saunders, H., 1993). Symbolically, the girls in the manual school had their hair cut short and wore it with a large bow, while those in the oral programme were allowed long hair (2007). Hair cutting, though a more extreme form, was also practiced in Magdalene Laundries of the era and symbolically represented the marking of these students as different, inferior, and childish. Indeed, the associations drawn between Sign Language and moral failure are highlighted by the fact that students from the oral programme have recounted that they were on the occasion sent to St Pius as a punishment for misbehaviour. Grehan stresses:

[i]t is important to emphasise that the threat of being sent to the 'Deaf and Dumb' school was held constantly over the girls in the oral programme. The 'Deaf and Dumb' school for them became synonymous with lack of intelligence, ostracisation and academic failure (Grehan, C., 2008: 19).

Religion also played a part. Sign Language was seen as a sin to be confessed to a Priest and students were encouraged to give up signing for Lent.

As well as strategies at play within the school, McDonnell and Saunders (1993) cite external strategies that were used to target the general public in obtaining public recognition for the oral successes of the school. Students succeeding in the oral programme were rewarded by having access to public exams, access which was not granted to students in the Sign Language section of the school (McDonnell, P. and Saunders, H., 1993). In public performances, signing students did not feature. Furthermore, the negative discourse of Sign Language used within the school was extended outside of school grounds and beyond the school life of children. McDonnell and Saunders' participant (1993) recounted that their employer was contacted by the principal of the school telling them not to allow D/HH staff to work together or to use Sign Language in the workplace, thus controlling the behaviour of students into their adult lives. As well as employers, parents were instructed not to sign with their children, creating communication difficulties in the home.

The continuity of the oral programme was ensured by establishing a teacher training programme which began in the 1970s that was built around an oral methodology and Sign Language did not appear on the curriculum until later. Through these internal and external strategies therefore, at play on the students and staff within the school, as well as future staff in training and the general public, a hegemonic medical model was established in the Irish system and simultaneously a negative discourse of Sign Language was promoted, the effects of which are still felt today. It is important to note that these strategies were not implemented without resistance. However, this discussion will take place in chapter 8, which places these resistance techniques in an international context as well as that of contemporary resistance strategies in Ireland.

Overall, the changes that took place at the middle of the last century created an educational environment saturated with both material and discursive techniques of discipline and domination, with the aim of classifying, segregating, surveying, disciplining, and subjectifying D/HH children through a pathological-medical model in pursuit of speech. As such, the use of Sign Language instead of the role it once

held as a valid and valued language among the student population became relegated as a threat to their educational and moral well-being. It is difficult to measure the extent to which this belief was internalised by the students, though the negative attitudes that some D/HH people still express toward Sign Language as well as the divisions felt within the Deaf Community between those students labelled as 'successes' and 'failures' to this day suggests that this subjectifying process had some degree of success. A further measure of success is the extent to which this hegemonic medical mindset is still visible in the contemporary setting. This will be discussed in chapter 7, which follows a brief outline of the structure of the contemporary deaf education system conducted in the next chapter.

Conclusion

Since the establishment of systematic education for D/HH children in France in the 18th century, there has been a growth in both the professionalization of the field and simultaneously, the medicalisation of D/HH children. The significance of the employment of a physician in a school for the deaf cannot be underestimated. The work of Itard during the early 19th century in Paris paved the way for a change in methodology that crossed almost the entire Western world. His systematic method of assessing, categorising and treating D/HH children is still practised today. Most importantly, he established speech as the new (and somewhat achievable) goal for D/HH children.

Social circumstances throughout the 19th and early 20th centuries secured the work that Itard had started. Colonisation, mass immigration and subsequent xenophobia in the United States, increased bureaucratization, Darwinism, eugenics and the rise of the scientific rationality all provided the impetus for a shift to oral education. D/HH children, according to the new social norms, were being held back by their use of Sign Language which aligned them to the barbaric populations of the Colonies. Spoken language was civilised, progressive, an indicator of development, and D/HH children deserved their 'chance' at that progress. The rise in audiology in the middle of the 20th century fuelled this system even further, providing the technological advances essential to the medical goals of deaf education. All the

while, however, deaf education in Ireland remained predominantly manual until the 1950s.

While the progress of deaf education from its establishment in Ireland in 1816 mirrors, to a great extent what happened across the rest of Europe and the United States, this similarity ends when it comes to the situation of oralism. While Claremont school (a comparatively small, private, Protestant establishment in Dublin) did make the change to oralism in line with the rest of Europe, the major stakeholders in deaf education, the Catholic institutes of Cabra, remained true to the manual system some 70 years after it had been abandoned almost everywhere else. While there are number of possible causes for this, none of which can be proven with any degree of certainty, it is likely that personnel changes in St Mary's school in the 1940s were significant factors in the move. In particular, the appointment of Sr Peter Flynn, herself with a background in education, familiarity with the UK system, as well as ties to the schools for the deaf in Dublin, seems to have been the catalyst for the ideological changes that took place in St Mary's, and some time later St Josephs, during the 1940s and 50s. Whatever the cause, the result was similar to what happened elsewhere.

Oralism in Cabra brought with it a strict mode of assessment, segregation and instruction. Scientific classification was used to distinguish between those children deemed capable of speech and those not. Segregation, through the use of spatial control, timetabling, and demarcation through uniform strata allowed staff to easily identify, and thus keep apart students in different streams within the school. The result was the stigmatisation of those using Sign Language, and the subsequent alignment of speech with success for D/HH children of the era. This stigma followed children into the community and into their adult lives, and the effects of the system are still felt on community relations to this day.

The oral method instigated in Cabra in the 1950s was consolidated in the 1972 report (Department of Education, 1972) examining deaf education in Ireland which paved the way for mainstreaming. The mainstream environment, under this philosophy, would provide an ideal opportunity for the ultimate segregation. By removing D/HH children from their D/HH peers altogether, and immersing them in

a full oral/aural environment, Sign Language could be replaced with speech indefinitely. This report was followed by the establishment of the visiting teacher service, as well as the teacher training programme in University College Dublin, both of which were populated by those who had worked in the Cabra schools during the changeover to Oralism. While a number of teachers who were trained in those programs have retired, many others continue to work in deaf education today. Thus, the legacy of this period cannot be underestimated in the context of the current system of mainstreaming. This is a system which views the advantage of mainstreaming as the potential it gives for normalising D/HH children through spoken language acquisition. While new staff members and subsequently a change in attitude towards deaf education may push for progress, the system at present is one which is rooted in a negative discourse of Sign Language and the stigmatisation of those who become members of the Deaf Community. Before turning to a discussion on how these features are still evident in the deaf education system today, and indeed how a hegemonic negative discourse of deafness is reproduced, the next chapter will first provide an outline of the current service provision in deaf education in Ireland.

6 Deaf Education in Ireland: a Quantitative and Qualitative Overview

Introduction

The previous chapter focused on the development of systematic education for D/HH children and how this provision changed course through the 19th and 20th centuries to push forward a hegemonic medical approach to deaf education. The examination of this medical hegemony will continue in chapters 7 and 8, looking at how that hegemony is both reproduced and resisted in the Irish context. However, before that analysis can continue, this chapter describes the current situation of deaf education in Ireland both quantitatively and qualitatively. First, it examines identification and early service provision to D/HH children. Second, it looks at the school choices available to parents and third, the school-based services in place in mainstream programmes. The limited demographic data available on D/HH students and their teachers will inform these discussions. It will also reflect on the experiences of parents as they seek to secure these services for their children. This chapter therefore is predominantly descriptive and reliant on empirical data. Theoretical analysis and discussion of this system will follow in the concluding chapters.

Identification²⁸ and Early Service Provision

Identification

As mentioned in chapter 2, Ireland does not have a Universal Neonatal Hearing Screening (UNHS) programme in operation. While the Department of Health and Children has approved the scheme, the budgetary allowances have not been made to allow for the purchase of equipment and staff training. Because of this absence of a neonatal screening service, parents with congenitally D/HH children are often

²⁸ The term 'identification' is favoured over 'diagnosis' through this thesis. The term 'diagnosis', due to its medical connotations is viewed negatively by members of the Deaf Community. Where diagnosis *is* used as a term, it is specifically to highlight the medical process involved. I am indebted to Dr. John Bosco Conama for drawing my attention to this matter.

unaware of their child's deafness until it is identified at their public health screening. This is a general health screening conducted by a nurse at approximately 6-9 months and a distraction test is used to check hearing. If children fail the test, they are referred for a re-test which, if failed, brings a referral for a more thorough audiological exam. However, there are often significant delays between initial identification and this final audiological exam.

The main finding in relation to identification, therefore, is that it is frequently delayed and often a source of frustration and concern for parents. The average age to receive a full diagnosis among research participants in this study was 19.4 months. This delay often comes between failing the distraction test conducted by the public health nurse and finally accessing audiology services. Parents in this research waited an average of nine months (with a range from 0-21 months) between these two points and rarely received any support services in the interim period. This was highlighted by most parents as a very stressful time when they felt vulnerable, isolated, and fearful for their child's future. It was exacerbated by poor communication between parents and baby and the increase in symptoms indicating that there was a hearing loss (lack of language development, failure to meet developmental milestones, and so forth).

The problems with early identification are further aggravated by the lack of services falling into place immediately following identification. The benefits of early intervention have already been highlighted (chapter 2), particularly in terms of alleviating stress in parents and improving communication between parent and child, and this is particularly true in the Irish context where late identification is already likely to have aggravated language delay.

Early Service Provision

Following identification, the D/HH infant can avail of a number of services from the Department of Health and Children (DHC) and the Department of Education and Science (DES). Most of the DHC services are provided through audiology clinics and include clinical assessment of hearing, audiological and speech and language therapy (SLT) services, hearing aid services, and medical interventions to improve

hearing levels. While there are a number of services provided by the DHC, specialised services in education are more limited. Unlike the situation presented to many other children with disabilities, there is not the same difficulty with the overlap of medical and educational service provision in the case of deaf education (for discussion see Flatman-Watson, S., 2009). This is because, from the time of identification, the visiting teacher service from the DES is provided to coordinate all service provision from both the DES and the DHC. As a result, there is, to an extent, and 'one-stop shop' where parents of D/HH children can access both information and negotiate service provision.

There are two education support services specifically for D/HH children which are provided from pre-school through to third level: the Visiting Teacher Service (VTS) and the Irish Sign Language home tuition scheme. As well as these home-based services, there are a very limited number of school options available specifically for D/HH preschool children. Of course, the mainstream preschool system is also an option but no specific services to address the needs of D/HH children are provided therein. Since these services generally last for at least the child's primary school career, some of the material below from parents reflects on the later periods of service provision. However, they are included here since they give an overall impression of the service which is provided as part of the early intervention structure.

Overall, the main concern of early service provision for D/HH children is to alleviate the instance of language delay. This can be done by providing access to speech (through audiology and SLT), by providing Sign Language (through the ISL home tuition service), or a combination of both. The services available are described in detail below, beginning with those from the DHC (audiology and SLT) and continuing with DES services (VTS, ISL home tuition and school placements).

Audiology

While speech and/or Sign Language can be used with D/HH children in early intervention, speech is overwhelmingly the most common choice in the Irish context. This is due to a complex combination of social and historical factors which

privileges the use of speech over sign with D/HH children, as was discussed in chapter 5. As a result, audiology and SLT services are of paramount importance if the 'speech route' is to be successful for D/HH children. The implications of this imbalance towards speech-oriented services will be further discussed in the next chapter.

The first main form of intervention following identification is from audiology services. This service is rehabilitative in nature, attempting to provide some form of assisted hearing to the D/HH child through amplification. Audiology services on a national level appear to be under-resourced and provision was deemed as unsatisfactory by the majority of parents involved in this research. In spite of a general negative view of audiology services among parents, only minor delays were reported in early intervention through the supply of appropriate amplification to the child in the form of hearing aids. It seems that once a full diagnosis is received through audiology services, the provision of hearing aids is a priority and follows swiftly. However, a number of problems persist regarding later access to audiology services.

In particular, delays were experienced with obtaining routine appointments for repairs and in obtaining upgrades to hearing aids. Long waits for appointments for audiology assessments and for essential repairs to be carried out on hearing aids was a recurring factor for D/HH children in mainstream school placements as hearing aid amplification is crucial to their continued access to material in the classroom. While many audiologists strive to ensure that there are spare hearing aids available in the event of equipment breaking down (Pitt, personal communication February 2009), several parents reported delays in repairs largely due to vacant audiology posts. The extensive waiting list and vacant positions remaining unfilled were the most commonly cited grievances for parents. This is no doubt due to the marked understaffing in the Irish context (Pitt, personal communication February 2009).

As well as delays to service provision, parents were also concerned about the difficulty in obtaining upgrades to hearing aids. Hearing aid technology has advanced greatly over the last number of years and for many children, digital

hearing aids now provide much higher quality of sound than was previously available through analogue devices. For those children who cannot avail of cochlear implantation, digital hearing aids may provide access to speech sounds and thus assist in acquiring spoken language. However, many of the parents involved in this research spoke of engaging in lengthy battles with service providers to try and acquire digital hearing aids for their children.

While both delays to service provision and upgrading were common among many parents, it was also apparent that there was great regional inequality. In particular, access to services in Beaumont Hospital provided a much higher level of service provision than that experienced by those availing of regional audiology services. Since its establishment in 1995, the National Cochlear Implant Programme at Beaumont Hospital in Dublin has played a significant role in medical intervention for D/HH children. The National Cochlear Implant Programme is a multidisciplinary programme consisting of three audiological scientists, two senior speech and language therapists, two senior teachers of the deaf and a senior clinical psychologist. Audiological services provided include behavioural and objective hearing tests for newborn children through to geriatrics. The speech and language therapists and teachers of the deaf provide services to the children both before and after the cochlear implant operation. A clinical psychologist is on hand to assess clients who have additional needs, including behavioural problems or emotional issues. There is also an Ear Nose and Throat team to provide surgical management of middle ear problems or to conduct implantation for profoundly deaf clients. If the client needs to have an Auditory Brainstem Implant (ABI) fitted, a neurosurgeon performs the surgery. Since 1995, there have been 268 Cochlear Implant surgeries performed in Beaumont. Figure 6.1 and 6.2 below summarise the figures provided by the Beaumont Cochlear Implant Programme (original data supplied by Beaumont in January 2007, with statistical analysis conducted personally. Updated material requested in late 2008 and again in early 2009 but not supplied).

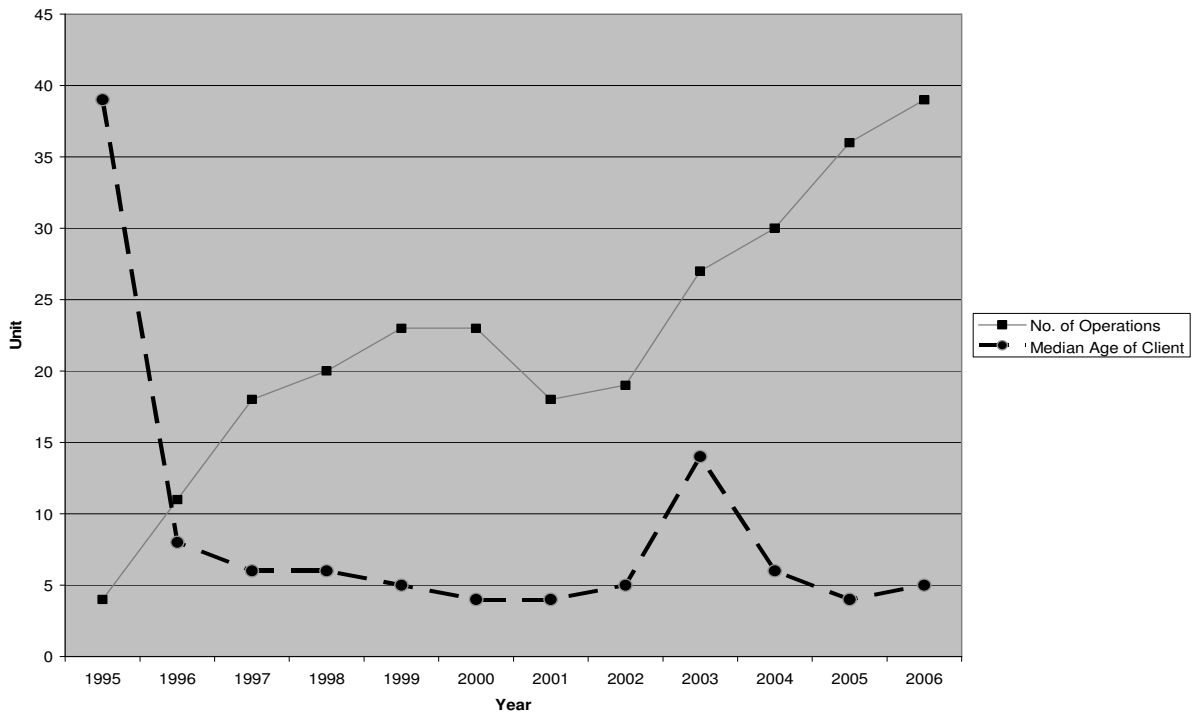


Figure 6.1: Number of Cochlear Implant Operations and Median Age of Client from 1995 to 2006

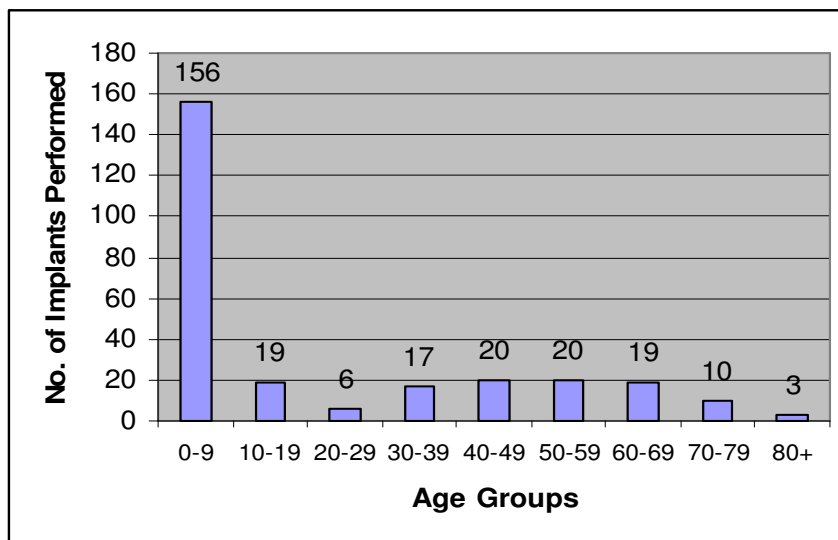


Figure 6.2: Total of Cochlear Implants by Age Category from 1995 to 2006.

Figure 6.1 above shows that the number of operations conducted at the cochlear implant unit per annum has risen steadily from 4 in 1995 to 39 in 2006. The age of

the clients has also decreased over the last 10 years and the vast majority of implant clients are now under the age of 10. In fact, 131 implants have been carried out on children under five, in other words at preschool stage (figure 6.2). The most common age for an implant to occur is 2. It is clear, therefore, that the physical surgery and therapy surrounding the cochlear implant programme makes up a large part of many preschool deaf children's lives.

As a result, there are increasing numbers of students in primary and secondary education who have been fitted with cochlear implants. The impact of cochlear implants on service delivery in deaf education is likely to increase over the coming years, highlighting a need for improved acoustic treatment in schools, speech and language therapy services, and potentially smaller class sizes. To date however, there has been no major assessment conducted on the physical design aspect of mainstreaming deaf education in Ireland.

Several parents spoke of the high quality of service in Beaumont hospital when compared with local services. However, this is a complex issue dependent on factors related to funding, diversity of workload, and professional interaction. Due to enhanced government funding, Beaumont Cochlear Implant Programme is in a position to offer a greater range of hearing aids than are currently provided through local services, which are restricted in the contract aids that they receive (Pitt, personal communication February 2009). Furthermore, lack of funding for staff training in these technological advancements have created a plethora of options for audiologists who have not been up-skilled following these developments (Pitt, personal communication February 2009). Regional audiology services cater for a large and diverse population of whom D/HH children make up a small percentage, where the Beaumont team specialise in those with profound hearing losses of whom a large majority are children. Regional audiologists, on the contrary, often work in isolation from other audiologists and do not have the benefit of the multi-faceted team working in Beaumont (Pitt, personal communication February 2009). A significant number of D/HH children have access to the Beaumont programme nonetheless, and 18 of the children in this research had been seen by the Beaumont team with 15 having been fitted with cochlear implants.

In comparison to high satisfaction levels with Beaumont, the lack of available funding and relative isolation of audiologists from each other may be the cause of the sense of dissatisfaction experienced by parents with regard to local audiology services. As a result of this, those with access to the Cochlear Implant programme rarely avail of services locally and instead request appointments with Beaumont because of the level of access available compared with local audiology services. While the quality of service provided in Beaumont is commendable, it raises questions about the equity of services on a national basis considering the large volume of children not suitable for the Cochlear Implant programme. As well as issues with audiology services, many parents spoke of the frustration at the lack of additional services immediately after identification to assist with language development.

Speech and Language Therapy

The provision of appropriate amplification is the first step in service provision following identification. Amplification is used to provide access to spoken language and to provide auditory stimulation for the D/HH child. However, access to sound alone is rarely sufficient if the D/HH child is to make progress in acquiring spoken language. The provision of SLT is an essential, though largely problematic area on a national level. In spite of the recent increase in college training places for speech and language therapists, the staff recruitment embargo and poor working conditions in the public health sector mean that this service is still desperately under-staffed (O'Brien, C., 2008). Few parents were satisfied with the level of service provided and their complaints largely fell into three categories; a) the length of wait for SLT services, b) the lack of continuity in SLT services and, c) the distances travelled for said services. Like the discussion on audiology services above, these services are not exclusively early intervention based but often continue through the child's primary schooling.

While there were few delays with immediate access to audiology services following identification, the opposite was the case for SLT where extensive waits for services to start were a grievance for many parents. There is great variation in

access to SLT services and a number of factors, including the presence of additional disabilities, educational placement and geographic location, all influence the level of access to services. Most parents reported being put on waiting lists for initial SLT services, some for a number of years, with almost no parents reporting immediate access to such services. Those parents with swift access to services generally lived in the Dublin area and were also on the Cochlear Implant Programme, availing of SLT services through Beaumont hospital.

Once services are received, continuity is also an issue. Outside of the Cochlear Implant Programme, when local public SLT services start, they are usually administered in a six-week block, with 30-45 minute sessions each week. Then, at the end of each six-week block, there is a wait for several months until another block is provided. Parents may get only two of those blocks a year which amounts to between six and nine hours of contact time with a speech and language therapist. Furthermore, there are often extended periods when these blocks are not even available due to the high turn over of staff in the field, or when a new therapist is encountered for each block as is the case when trainee speech and language therapists are on rotation in a particular region. This lack of continuity is of particular concern to those children living outside of Dublin who need intensive speech and language therapy in the early years following implantation but for whom regular travel to Beaumont is not feasible.

The issue of distance arose again for parents whose children were enrolled in schools which had a special class for speech and language disorders, with a resident speech and language therapist. According to Department of Education and Science Circular 0038/2007, the criteria for enrolment in a special class for pupils with specific speech and language disorders stipulates that “the pupil’s difficulties are not attributable to hearing impairment; where the pupil is affected to some degree by hearing impairment, the hearing threshold for the speech-related frequencies should be 40Db.” (Department of Education and Science, 2005). As a result, children who are D/HH may be attending a school with SLT provided, but they are disqualified from availing of this service. They must therefore be removed from the school premises to attend their public SLT.

This difficulty also arose in one of the units that had a speech and language therapy service in their school that *was* available to D/HH children, but not all of them. Some children were ineligible because they lived outside of the SLT's catchment area, in spite of attending school *within* that area. Those children not eligible for in-school SLT had to travel out of school (back to their catchment area) to avail of the service. Subsequently two of the children continue to miss one full school day a week for the duration of their six week block of SLT. The journey from the family home to SLT, then to the unit, and then home is a trip of approximately 160km, one the parents are not willing to make when SLT is provided.

This absence of coherent, continuous and accessible SLT services means that spoken language delay is further aggravated in D/HH children. Some parents reported declines in their children's speech acquisition because of the lack of intervention available locally. Others reported working extensively at home with their children on a daily basis to try and make up for the lack of services locally. The lack of SLT services on a national level is a worrying fact considering there is little in the way of Irish Sign Language intervention offered to D/HH children as an alternative to spoken language acquisition. Furthermore since communication in mainstream classrooms is primarily oral, and the overwhelming majority of D/HH children are enrolled in that setting, the combined problems of poor audiology and SLT services paint a grim picture of mainstreamed deaf education in this country.

Visiting Teacher Service

The most significant service available following identification is the Visiting Teacher Service, which holds specific responsibility for D/HH children. The VTS was established in 1972, following the publication of the Report of the Committee on the Education of the Hearing-Impaired. This report marked a change in the traditional provision of education for D/HH children in segregated schools in that it allowed for the creation of the VTS to serve D/HH children who were enrolled in mainstream schools across the country. While the legislative entitlement of parents to send their D/HH children to the local mainstream school did not come into force

until the 1998 Education Act, the provisions outlined in the 1972 report (Department of Education, 1972) paved the way for the integration of D/HH children in that setting.

This is an itinerant service from the DES and it coordinates between families, individual children, and health and education services. Its focus is on the provision of mainstream education to D/HH children and as a result, it does not have the same level of contact with those children in schools for D/HH. The most recent data available from the DES is the 2005/06 caseload information²⁹ which reveals that in that school year, 184 preschool D/HH children nationally availed of the VTS. This figure has increased significantly from 125 preschool children in 2001/02 (Advisory Committee working documents, 2004). The service lasts from identification through to third level, in other words the educational life-span of the D/HH child. In recent times it has changed considerably in that it is one part of the special education service. As Williams highlights:

In the context of Irish schools, the [visiting teacher], once the sole support figure for children with hearing loss, is now part of a multi-faceted model of service provision, consisting of resource teachers, learning support teachers, special needs assistants and special needs organisers (Williams, G., 2007: 2)

The role of the visiting teacher ranges from providing support and advice to parents, to coordinating services within the school. Since the rise of mainstreamed education, the role has become more advisory in nature as visiting teachers counsel mainstream staff on working along with their D/HH student (Williams, G., 2007). In Ireland, the VTS is managed by the regional offices and there is an inspector for the VTS within each of the 10 educational regions. These answer to the Directorate of Regional Services, a centralised office. Individual visiting teachers work largely alone, though they have management group meetings frequently with other visiting teachers working in their area. While the VTS does not adhere strictly to the boundaries of educational regions, there is roughly one visiting teacher per county.

²⁹ This figure is the only data that was released from the VTS caseload survey, and it took approximately 6 months to negotiate. It was eventually provided to be included in a report for the National Council for Special Education, the managing body of the VTS.

Few delays were reported in the provision of this service, except in the case where the position for a Visiting Teacher had not been filled in a particular area. Another possible cause of delay is when identification occurs at the beginning or during the summer months, when the VTS is suspended for the holidays. The visiting teacher is responsible for authorising many of the services available to D/HH children, such as sound field systems for classrooms, Irish Sign Language home tuition, or the domiciliary care allowance. When a particular region is without a visiting teacher, his/her absence can delay service provision and isolate parents from the information they need in obtaining supports. Similarly for staff, when a visiting teacher is not appointed for an area, securing services and the upkeep of equipment within the school can be difficult. Overall, it is a pivotal service for D/HH children in mainstream education.

Irish Sign Language Home Tuition Scheme

Along with the range of rehabilitative services outlined in the previous section, the Irish Sign Language home tuition scheme was established in the mid 1990s and is the main source of instruction and support provided to hearing families wishing to use ISL as a means of communication with their D/HH child (for a discussion on the service see Leeson, L., 2007: 94-96). The service is home-based with a D/HH tutor visiting the family to provide instruction in ISL. One hour a week is provided during term time, and this increases to 7 hours a week during the summer. For this reason, it is one of the most frequent services available to families with D/HH children and is one of the few services continuing through the summer months.

In spite of the fact that this service has been in place for over ten years, uptake of the scheme is still relatively low. For example, in the 2005/06 school year, there were 84 families across Ireland availing of the service. This contrasts significantly with the almost 1200 students across age groups availing of the Visiting Teacher of the Deaf Service in the same year (Mathews, E., 2007). While the low uptake may be caused by a number of factors, including but not limited to lack of interest or lack of tutors, it is more likely from the evidence of this research that it is

due to a lack of information provided as well as dissuasion tactics steering parents away from the service. This will be discussed further in the next chapter.

Preschool Services

School-based early intervention services for D/HH infants are scarce. In the process of this research, a number of pre-school organisations were contacted (e.g. the Irish Preschool Playgroups Association, the National Children's Nurseries Association) to enquire about the availability of specialised services for D/HH children at this age. None of the organisations contacted were able to refer to a service that would deal with D/HH infants. While there seems to be a lack of awareness amongst these organisations, there were at the time two preschools in the country that cater specifically for this cohort: the Model School for the Deaf Project (MSDP) and the Midwest School for Hearing-Impaired Children. There is also a Dublin-based project run through Deafhear.ie (formerly National Association for the Deaf) called Play Learn Understand Myself (PLUM).

The MSDP was a pilot project funded by the DES that started in 2000. The project had a family-centred approach to education, providing support to parents and guardians in early intervention education with D/HH children. Services provided include speech and language therapy, consultancy services, and support groups (www.childcare.ie/msdp accessed January 2007). There were nine students enrolled for the first two years of this project but the numbers declined following that and there were no students involved when project ended in June 2007 (Personal communication, MSDP). A number of issues have been raised as to why student numbers have been so low and lack of awareness seems to be a key issue (Leeson, L., 2007). This would raise questions about the work of the VTS, who are responsible for providing parents with information on services available to them.

The Midwest School for Hearing Impaired Children which provides education for primary and secondary age students also has a preschool service joint funded by their parents' association and the Health Service Executive through the DHC. At the time of data collection in 2007, there was only one student enrolled (Personal Communication, Midwest School for Hearing Impaired Children, January

2007). Deafhear also runs an early education initiative called PLUM. However, although the programme is still running, numbers been consistently low and referrals are difficult (Personal Communication, Deafhear). The fact that so few children are attending a specialised education setting for D/HH children would suggest that other children may be attending mainstream preschools throughout the country or are in the home full-time.

As there is no official register of mainstream preschools that will cater for, or are currently catering for D/HH students, obtaining information proves very difficult. It would appear that these services are organised on an ad hoc basis, and depend largely on the willingness of the preschool to accommodate a D/HH child. A number of parents interviewed for this research commented on having their children enrolled in local playschools or crèches prior to attending primary mainstream school. Considering the importance of early intervention to ensure appropriate linguistic and cognitive development among D/HH children, it is surprising and worrying that known preschool educational placements (both within specialised and mainstream settings) are so scarce.

However, the responsibility of provision is uncertain. The DES is only responsible for providing education between the ages of 4 and 16. Early education for hearing children comes under the remit of the DHC. However, for D/HH children the VTS is provided immediately following identification, a service which is funded by the DES. It appears therefore that there is some crossover between these departments when it comes to the early education intervention for this cohort. There is no obligation on the DES, however, to provide early education for D/HH children, and services provided by the DHC do not have to specifically cater for D/HH children.

Schooling Options

The services described above are, on paper at least, available following identification and continue, to varying degrees through the child's school life. However, once the D/HH child starts school, a different set of services, those which are school-based, must be organised and implemented. These include human

resource services such as a resource teacher and special needs assistant and physical resource services such as assistive technology, acoustic treatments, classroom adaptations. Of course, deciding on a school is influenced by a number of complex and inter-related factors such as supports available, distance travelled, family background, and other personal factors. This section will look at the primary school placements available to parents, and the process of acquiring services once in school.

The Available Options

The three main choices available to parents in this research were schools for D/HH children, units for D/HH children within mainstream schools, and full enrolment within a mainstream school. These three options are available across both primary and second level, although significantly fewer units are available at second level. Demographic information on these school placements is presented below, to give a general outline of the extent of the mainstream phenomenon across Ireland.

Schools for D/HH Children

There are three schools for D/HH children in Ireland which cater for both primary and secondary level. They are Marian Primary School (second level is St Mary's School for Deaf Girls) and Edmund Rice Primary (second level is St Joseph's School for Deaf Boys), both in Cabra, and the Mid-West School for Hearing Impaired Children in Limerick which has both primary and secondary age group children. While St. Mary's and St. Joseph's have both been recognised as secondary schools, the Midwest School for Hearing Impaired Children in Limerick is not accredited by the DES as a post-primary school and must conduct its classes within primary school times. This is in spite of the fact that the vast majority of its students are of post-primary school age. Details on student enrolment and teaching staff (including Special Needs Assistants and Resource Teachers) for these three schools are available below. Since the focus of this thesis is on primary education, only statistics for that sector will be discussed (see Table 6.1). Please note however that the data from the Midwest School for Hearing Impaired Children for staff numbers

and for pupil characteristics could not be separated out between the primary and post-primary school categories.

As table 6.1 below illustrates, from 1997 to present there has been a sharp decline (52%) in student numbers at primary schools for D/HH children. While this coincides with the introduction of the 1998 Education Act that provided parents with the legal right to send their child to the local mainstream school, it is likely that this trend had begun before that and was simply accelerated by the passing of this act. Whatever the cause, there is no denying that numbers attending specialised primary services for D/HH students are in decline.

Furthermore, there has also been a decline in teaching staff. The apparent stability in the total number of teachers can be accounted for by the fact that there were four part-time teachers employed in the Mid-West School for Hearing Impaired Children that were not counted in the 2003 statistics. Since then, these teachers have all been made full-time. It should also be noted that these six teachers teach students at both primary and secondary age. For this reason, the apparently low student-teacher ratio in the Midwest School for Hearing-Impaired Children is misleading. In spite of the decrease in teacher numbers, there has, however, been an increase in Special Needs Assistants in two of the schools. This increase is likely to be in line with a general growth in Special Needs Assistants across the board and/or may be a response to the growing demand for Irish Sign Language tutors. Frequently, these positions are filled by people who are Deaf and employed in a special needs assistant capacity. Overall, it can be noted that services in primary schools for D/HH children have been declining gradually over the last number of years.

	Edmund Rice Primary School	Marian Primary School	Mid-West School for Hearing Impaired Children	Total
No. of Teachers ³⁰				
2003/04	9	13	2	24
2006/07	8	10	6	24
No. of Resource Teachers				
2003/04	2	2 (part time)	0	4
2006/07	0	2 (part time)	0	2
No. of SNAs				
2003/04	7	7	4	18
2006/07	9	6	6	21
No. of Pupils				
1997/98	54	62	14	130
2003/04	24	40	12	76
2006/07	27	28	8	63

Table 6.1 Staff and Student Numbers in Primary Schools for the Deaf from 1998 to 2007³¹.

Units for D/HH Children in Mainstream Schools

In addition to the schools listed above, there are also units for D/HH in mainstream schools. These are often referred to in the literature as Partially Hearing Units (PHUs), self-contained units, special classes, or units for hearing impaired children. For this thesis, they will be known simply as units. These units function as separate classes within mainstream settings with varying levels of optional integration, from those D/HH children who receive all of their education (except extra-curricular activities) in the unit, to those who are integrated most of the time but may use the unit for resource provision.

³⁰ Number of teachers includes the principal.

³¹ Note on data from Table 6.1: all 1997/98 and 2003/04 data provided by the Advisory Committee working documents, 2004. 2006/07 data provided by Mathews.

At present, there are eight such units at primary level³². These are located in Scoil³³ Chaitríona Junior, Renmore, Co Galway (opened 2005); Scoil Chaitríona Senior, Renmore, Co Galway (opened 2007); Darley National School, Cootehill, Co Cavan; St Matthew's National School, Ballymahon, Co Longford; Geashill National School, Geashill, Co Offaly; St Columba's Girls' National School, Douglas, Co Cork; Scoil Náisiúnta an Chroí Naofa, Tralee, Co Kerry; and Holy Family National School, Ennis, Co Clare. Many of these units are located where there were once schools for D/HH, but due to declining numbers, they have amalgamated with a mainstream school in the area. This would also explain the absence of any unit in Dublin, where the remaining schools for the deaf are large enough in enrolment number to have not been amalgamated with a mainstream school. In the last number of years, 2 units have also opened at second level: one in the Community College in Ennis and the second in Bishoptown Community School in Cork.

Due to the lack of available data on the demographics of units, some basic quantitative data was gathered through an annual survey. Since 2006, this survey has been conducted among the units for the D/HH children in primary mainstream schools. The survey was largely concerned with monitoring changes in student and staff demographics and characteristics but also included some qualitative questions regarding levels of inclusion, access to resources, and any impact of the recent economic downturn on services. This data was combined with figures supplied to the Advisory Committee in the school years 1997/98 and 2003/04 (Leeson, 2007). Some of the questions changed from year to year based on feedback from schools or because of requests from other interested bodies (e.g. Centre for Deaf Studies) to examine a particular issue.

Regarding student demographics, it is important to note that while there was a general downward trend in student numbers, particularly after mainstreaming legislation, this decline has slowed in recent years, as illustrated by figure 6.3

³² At the time this thesis was written, a ninth unit had been added in Waterford. Its data is not included here however, as its opening was after data collection was completed.

³³ Scoil is the Irish (Gaeilge) word for school. Many national schools in Ireland will have a saint's name. For example, Scoil Chaitríona means St. Catherine's School.

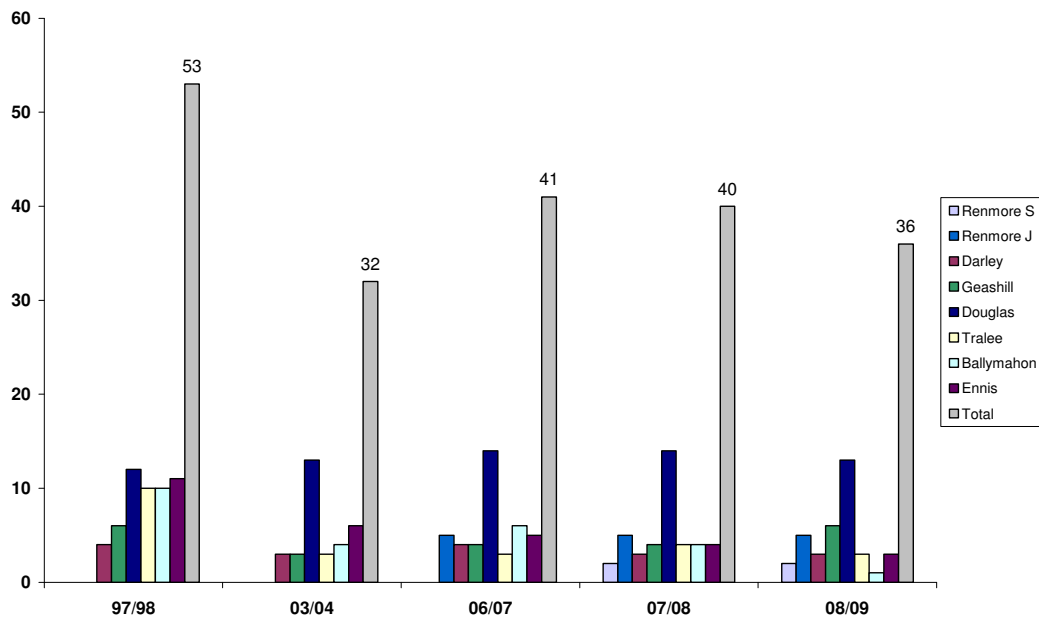


Figure 6.3: Student numbers in units over time.

A significant decline in those pupil numbers reported by the Advisory Committee in 97/98 (n=53) to those in 2003 (n=32) is mostly due to a drop in pupils in 3 larger units (Tralee, Ballymahon and Ennis) from 10 pupils down to 3-4. This decline is probably representative of the mainstreaming movement and the general decline visible in schools for D/HH children during the time. The other smaller units were relatively stable at the time. The recovery of student numbers from 06/07 reflects the opening of a new unit in Scoil Chaitríona, Renmore in Galway and the general growth in population in Ireland during the late 1990s .

It should be observed that quite a number of those students in units from this growth period were from families migrating into Ireland, evident from data supplied on the language of the household of children enrolled. Data was not gathered on the language of the child's household until 2007, and was included following school visits which highlighted the diverse range of students among the small numbers in attendance in units. Data from 07/08 showed that 30% of all children in units in that year were from families where English was not the primary language of the home (hereafter referred to as English as a Second Language (ESL) households). This declined slightly to 27% in 08/09. This total reflects a range where some units had

no ESL household students and one unit which had 100% ESL household students. This is part of a larger trend of the growing complexity and diversity in student characteristics in units .

From 2007, data was also gathered on the numbers of children with cochlear implants (CI) as well as those who had multiple disabilities (MD) other than their hearing loss being enrolled in units. It should be noted that there may be some discrepancies with the data on MD students and that these figures should be used as rough guides only. The question was phrased “How many, if any, of your students have an additional disability (other than their hearing loss)?” It has since become apparent from teacher comments that there is often a difference between a) the number of students with diagnosis, b) those awaiting diagnosis, and c) those not diagnosed with an additional disability but the teacher suspects there may be one. From 2009/10 onwards, this question has been split into these three categories to establish if there are large numbers of suspected MD students who have not been diagnosed. This represents an overall difficulty with diagnosis of additional disabilities among D/HH children due to the often inappropriate testing methods and a lack of awareness of the language issues at play. This data, along with figures on students from ESL households is presented in Table 6.2 below.

	2007/08	2008/09
<i>% ESL Household Children</i>	30%	25.0%
<i>% Children with MD</i>	27.5%	25.0%
<i>% Children with CI</i>	45%	38.89%

Table 6.2 Some student characteristics in units.

Teachers were also asked to categorise their students across a number of different groupings such as levels of hearing loss and child’s preferred communication method. Again, data gathered in this section is somewhat problematic (see chapter 2 and discussion above). That said we can draw from this information that the majority of students currently enrolled in units are in the

profound to severe category (78%). Table 6.3 below indicates that the majority of students in units use some form of manual communication, either Irish Sign Language or spoken English supported with signs. A significant number also use spoken English as their preferred method of communication. The difficulty with teacher-reported data in this category is that they may not recognise what the students' *preferred* method of communication is and instead indicate what method of communication they use with their students.

	2007/08	2008/09
<i>Irish Sign Language</i>	30.00%	38.89%
<i>Signed English</i>	2.50%	2.78%
<i>Spoken English</i>	32.50%	33.33%
<i>Spoken English supported with signs</i>	30.00%	25.00%

Table 6.3: Preferred communication method as reported by teachers³⁴.

Another difficulty with the data above is the disproportionate reporting of ISL being used over Signed English. On observation in units, it became apparent that signed English was much more commonly used by teachers than ISL. However, the child's preferred method of communication may indeed be ISL. In spite of the problems with this data, these findings show that a significant number of children in units continue to use some form of manual communication to support their learning.

In addition to student demographics, data was gathered on staffing numbers and characteristics. In general, staff numbers have remained relatively constant since 2003 (data is not available for 1997/98). While some units have lost a teacher, this has been compensated for by the opening of 2 new units in Galway since 2005. There has also been an increase in the number of full time SNAs. In 2008/09, there were 10 teachers and 9 full time SNAs employed in units. Data was supplied on the number of Deaf staff employed and the number of staff members holding qualifications relating specifically to the education of D/HH students. Of the 19

³⁴ The totals do not add to 100% as some teachers did not report on all students in the unit.

staff members in units, only 4 are Deaf and they are all employed as SNAs. In total, only 2 members of staff across all of the units had obtained a qualification specifically for the education of D/HH children (both holding the HDipTD). One further staff member is currently in training for the PGDip course in Hearing Impairment through the University of Birmingham. The majority of teaching staff in the units had, however availed of the Special Education Support Service (SESS) training/in-service course provided in the last 2 years and cited it as a source of valuable guidance. A number of units reported training courses or qualifications in ISL, but these were excluded as they do not relate to education specifically.

In summary, while there are number of difficulties with the data gathered from surveys, some important conclusions can be drawn. Quantitative data gathered over the last number of years from units in mainstream primary schools shows that the decline in student numbers attending these units has slowed considerably and is relatively constant at present. Staff numbers are similarly constant though some units have lost both teachers and part-time SNAs in recent years. This has been compensated for by the creation of new posts in 2 units opened in Scoil Chaitríona Junior and Senior, Renmore, Galway in 2005 and 2007 respectively. Students attending these units are heterogeneous in terms of cultural and linguistic background, as well as levels of hearing loss and presence of multiple disabilities. In general however, the majority of students are in the profound to severe category. The use of cochlear implants and hearing aids is split almost evenly. Manual communication is still a significant feature of education in units along with Spoken English and the most common form of preferred communication reported is split almost evenly between Irish Sign Language and spoken English.

This data also allows us to draw some general conclusions about deaf education at present. Hearing professionals without qualifications relating to D/HH children still hold the monopoly of positions in these schools. Deaf individuals, where they are employed, work as assistants to teachers. Although ISL ranks highly as a preferred method of communication, few teachers reported high levels of accomplishment in its usage and instead many had availed of a basic 10 week evening course and used DVDs and dictionaries to complement their basic signs.

From brief observation undertaken while visiting the units, speech or signed English is the dominant method of expressive communication used by the majority of teachers in units, ISL is used by Deaf staff members and the children themselves alternate between the two depending on with who they are communicating.

Full Mainstream Programmes

Owing to the small numbers of students enrolled in both schools for the deaf and units, it can be deduced that the vast majority of D/HH students are enrolled in mainstream schools across the country. Unfortunately, this group is the most difficult to research in terms of demographic characteristics since information is not readily available. What we do know is that D/HH children in this environment have access to a number of supports within the school, namely resource teaching, assistive technology and a special needs assistant (SNA). These services will be discussed in detail below.

In spite of knowing what services are provided to D/HH children, there is very little else known of their experience in mainstream in Ireland. There is no available data on how they perform compared to their hearing peers, or to their D/HH peers across different placements. Nor is there research on how their linguistic, cognitive and social development occurs in this setting. As mentioned earlier, the VTS has caseload data on these students but does not release it. As a result, the group at the centre of this research is also that cohort that the least is known about, and that there is the greatest difficulty accessing data on. This raises fundamental questions about the management of deaf education services nationwide, and the running in particular of the VTS.

School Services

Human Resource Services

The main human resource services available to D/HH children in mainstream settings include resource hours (usually 4 hours a week or 5 for those with additional disabilities), a special needs assistant (ranging from part-time to full-time), and access to the Visiting Teacher Service. For resource hours most D/HH children are

withdrawn from the classroom. Some schools facilitate this resource time by scheduling it at the same time as Irish from which D/HH children are exempt, so that they do not miss other curriculum material, though this largely depends on the good will of the teacher. If students receive direct one-to-one tutoring from their VTS, this is frequently outside of the classroom also. Their SNA is a classroom-based resource.

In general, parents did not encounter difficulties accessing resource hours and the only problem arose when particular resource teachers showed poor deaf awareness. Resource teachers encounter children with a wide range of special educational needs and they do not necessarily have experience in deaf education. One family spoke at length about difficulties with their resource teacher, which is indicative of a situation where staff with no deaf awareness training can create problems for D/HH children:

Mother: there were problems with the resource teacher in primary school

Father: well she just didn't have any experience, even as a resource teacher she was just, and some of her approaches were...

Mother:... they were pretty bad!

Father: ineffective.

Mother: she was shouting at him all the time.

Father: (laughs uncomfortably) it was just great. She was getting frustrated, you know he was getting upset about going to the resource teacher. She was getting frustrated with him and she was just doing these mundane chores.

Mother: I was going in a lot talking to her, because we had no teacher of the deaf [visiting teacher] telling her this is what she should do, do this, this and this. (Parents 02).

Further to resource hours, the vast majority of children in this research had access to a SNA in the classroom. This was deemed as a particularly vital resource for the mainstreaming of D/HH children. During observation, it was apparent that the SNA assists the D/HH child in following the curriculum in the class, provides cues for changes in topic, repeats the teacher's directions, and helps the child to follow the often rapid changes in speaker in the classroom. However, the role of the SNA as laid out in circular SP.ED 07/02 stipulates that they are not to engage in teaching activities and are primarily employed for the care needs of children. This is clearly not being followed in the case of D/HH children where the SNA is crucial to

a large extent in successful access to the curriculum, as illustrated by the following field notes from observation:

She (the SNA) is obviously engaged in teaching activities with him, in spite of the fact that this is against guidelines for special needs assistants. For example, Chris got stuck on the question 9×3 , and the special needs assistant showed him how he can use the tables provided at the back of his homework journal to find the answer. Chris also got stuck on 6×7 and used the journal by himself. The special needs assistant uses attention gaining techniques common to the Deaf Community such as tapping him on the shoulder or elbow. She also uses some small gestures to clarify what she is saying. (Observation field notes, 15/9/08).

In spite of the crucial role the SNA plays for many children, it was a service several parents had difficulty acquiring. Most parents stated that they were offered a part time SNA for their child, which would result in access to the curriculum for only half of each day. Many parents fought and lobbied the DES to secure a full time SNA:

[w]hat happened was that when we went down to the school to register him we told them, and we had to write a letter to the Department of Education. [...] He said the Department grants them 17 hours...17.5 hours I think it was. The full time is 22.5 hours. Basically they were giving him a Special Needs Assistant from 9.00 am til just before lunch time. So he'd have to do lunch time and the afternoon alone without someone. [...] So we had to write a letter to the Dept of Education to ask for the extra hours. So we got them anyhow. So he has the full hours (Parent 01).

While most parents were eventually awarded full time SNAs, the recent announcements of education cutbacks signals the danger that these resources may be retracted. One mother who was interviewed later in the research following the budgetary announcement was distraught following the removal of her son's full time SNA at the beginning of this school year:

[t]hen this year we had major problems again because we were told just the day before we went on holidays, and it was the visiting teacher that told us, the school didn't inform that the SENO [special educational needs officer³⁵] again had halved, well she was leaving him access to an SNA but he was sharing it with another child in another class. [...] And his resource hours have also been cut, he seems to be only just getting two hours a week, three forty-five minute sessions [...] I'm back to a child that's not

³⁵ The special educational needs officer (SENO) is a recent addition to the special education landscape and acts as an assessor to the need of particular students and grants what resources are available to them.

sleeping at night, he's crying, we've had a couple of episodes already when he's been in tears in school and I'm trying to get on to the local T.D. I have a letter half written to go back into the principal and back into the SENO. She's [the SENO] already sent me out a letter to say that it doesn't matter what anybody says, psychologists, visiting teachers, any of those reports, it doesn't matter what the reports say, it's what she decides. (Parent 20).

There is now the danger with increased cut-backs in the education sector that D/HH children will lose their access to full time SNAs on the grounds, like Parent 20 above, that their children do not have care needs which would qualify them for SNA provision. This is of particular concern for those children who are using their SNA as a means of accessing the curriculum through ISL.

A large percentage of children enrolled in units across the country use some form of manual communication in their education. The level of Sign Language training (be that ISL or Signed English) received by the teachers in units however, showed great variation. One teacher who has been working for a number of years in a unit said:

[w]ell I got, I had ten 1 hour classes, the Department of Education put them on here for us and then after that it's literally learning it from a sign language book and the CD...[...]...but I wouldn't consider that I'm fluent by any manner of means. (Teacher 10).

As a response to this situation, a number of units reported using a Deaf SNA as an interpreter in the classroom between hearing non-signing teachers and D/HH signing children. This creates a number of problems including but not limited to responsibility of teaching duties, the role of the SNA, the level of qualifications amongst teachers, and student-teacher-SNA interactions. Most often, teachers had received basic training in ISL or signed English at the beginning of their post through evening classes. Several spoke of using the ISL dictionary or CD as a method of acquiring vocabulary and only one teacher had advanced beyond the levels provided at evening classes.

Physical Resources: Assistive Technology

While a large proportion of children enrolled in units use some form of manual communication, almost all of the children in full mainstream programmes

communicate exclusively with spoken English and access communication in the classroom through assistive technology such as radio aids or a sound-field system. A radio aid is an individualised device which amplifies the teacher's voice (via a microphone) in such a way that it is only heard by the D/HH child. In contrast, a soundfield system amplifies sound in general for the entire classroom. Usually, it is just the teacher's voice which is amplified, though some schools use a roaming microphone so students' voices can also be heard. Based on observation within classrooms as well as interviews with teachers, this technique was rarely implemented among the research participants and highlights an oversight in the current system which allows access to the teacher's instructions, but rarely provides access to student answers, questions or comments.

As well as assistive technology, structural adaptations may also be necessary and all of the classrooms visited had made some adjustments to the classroom to improve access for the D/HH child. Some adaptations simply meant selecting the most appropriate classroom for the class that had a D/HH child, one with carpet and low ceilings. This was rarely implemented however. More commonly, teachers simply attempted to position the D/HH student in a seat where they would have optimum visibility of the teacher. However, problems remain with the seating position of children in classrooms, in particular when the teacher worked at the blackboard, as field notes from observation illustrate:

It is a large and spacious classroom with a high ceiling, carpet on the floors, large windows running the length of the room, with blinds on the windows. There are four large desks, two seating eight children, one seating seven and one seating six. Chris sits at a desk with seven other children. He sits to the left hand side of the classroom which means that his view may be obstructed while his teacher is writing on the blackboard. However, were he to be seated on the opposite side of the classroom, he would be facing the windows. As it stands, he sits at a slight angle to the windows, with the light coming over his left shoulder. His special needs assistant sits just behind him in the classroom. [...]It was obvious that the teacher struggles to maintain proper communication with Chris (see position on figure 6.4 below) while she was working at the white board. This is because she is right-handed. In order for her to use the whiteboard she has to stretch her right arm across her face thus blocking the view of her face for Chris who sits behind her to the left. She did make an attempt, but it was clearly awkward, and I assume that if I hadn't been there she wouldn't have been so self-conscious of that. (Observation field notes, 15/9/08)

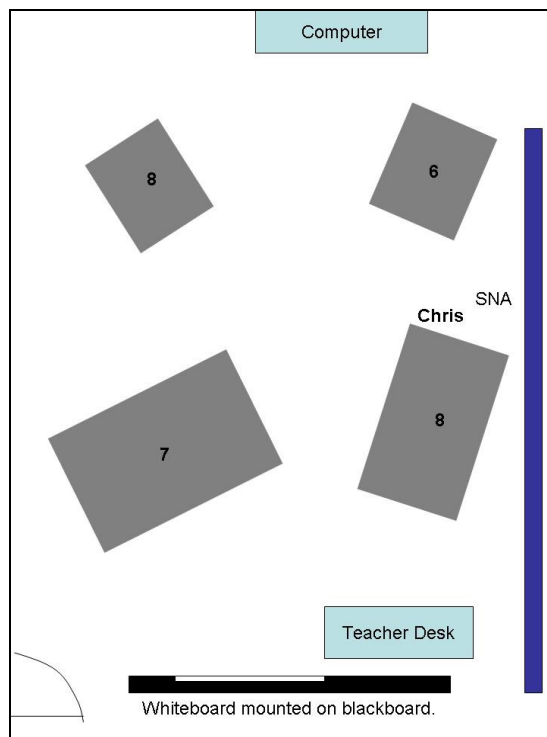


Figure 6.4: Sketch of Chris's classroom.

It is unreasonable to expect the classroom teacher to be aware of the D/HH child at all times. What the field notes above fail to capture is that the mainstream classroom has become an increasingly diverse environment in the past decade with increasing numbers of children with special educational needs along with children from ESL families. The combination of these factors means that the class teacher may be unable to cater all of her teaching techniques for the D/HH child. For this reason, the availability of appropriate assistive technology equipment along with a full time SNA in the classroom is vital for the successful integration of this cohort.

However, the difficulty accessing human resource services is repeated in attempts to access assistive technology for the D/HH child. It is likely that these difficulties are linked to those problems availing of audiology services highlighted above, as similar suppliers are used. Many parents spoke of lengthy waits for radio aids, sound field systems and repairs of same. Two parents resorted to purchasing a soundfield system privately for their child's school because of delays in provision

from the DES. Some children go for extended periods without this equipment and their access to spoken language in the classroom is subsequently compromised:

I wanted to get a radio aid for his analogue hearing aids. But the radio aid never turned up from the Department of Education. And I phoned them continually about that radio aid, and that was December. And I was looking for the radio aid in June, and this was December. [...] Well I was obviously requesting this radio aid and it never arrived. I mean the Department of Education are a joke. I remember ringing them and they never answered the phone, and they never replied to anything (Parent 02).

For the majority of D/HH children, who are relying on oral communication in the classroom, the consistent provision of services such as assistive technology and full time SNAs is essential to ensure that they can access the curriculum in a meaningful manner at all times in the mainstream classroom. To integrate a D/HH child without adequate supports is to limit their educational and social development. Furthermore, since it is unlikely that the D/HH child will know when they are missing out on information in the classroom, staff and service providers must be vigilant in monitoring the quality and continuity of access to the curriculum.

Conclusion

When D/HH children are born, a variety of services are put in place following identification to alleviate the difficulties of language acquisition. These services are particularly urgent considering the widespread delays in identification of deafness in Ireland. The services provided cater for both spoken and sign language development, although services for spoken language (audiology, SLT) are more common, more widely used, and better resourced. Information on the lack of resource given to the ISL home tuition service, in contrast, will feature in chapter 7. Services in early childhood are complemented by a number of specific educational resources, both human resources and technological, made available when children start school. In spite of the provision of services in policy, delays in accessing these services and the lack of continuity once services are approved are common problems cited by parents. This situation has likely been aggravated by the recent economic downturn.

A number of school placements are available to D/HH children, though the vast majority are enrolled in full mainstream programmes. As a result, there has been a nationwide decline in children attending specialised services such as schools or units for D/HH children. While most children enrolled in such specialised services use some form of manual communication, it can be assumed that those in full mainstream programmes are using oral communication through their schooling and services are therefore geared to that. Due to the large uptake of mainstream education, many early intervention services are now geared at preparing children for mainstreaming by aiming for spoken language acquisition. Simultaneously, mainstreaming has become a complementary force in the medical pursuit of speech for D/HH children, whereby their educational placement can now provide a full immersion in spoken language. The implications of this new development and what it means given the historical context of the pursuit of speech in deaf education makes up the discussion of the next chapter.

7 Reproducing a Hegemonic Medical Discourse in the Irish Deaf Education System.

The erosion of choice, the closure of possibilities, the manipulation of outcomes, the threat of force, the assent of authority or the inviting gestures of a seductive presence, and the combinations thereof, are among the diverse ways in which power puts us in place (Allen, J., 2003: 196).

Introduction

Allen (above) reminds us of the complex and dynamic nature of power. This chapter will examine how the various modes of power, such as "the closure of possibilities" and "the assent of authority" work to reproduce a hegemonic medical model of deafness in the current system. Chapter 5 discussed how the origins of the social authority of medicine from the 18th century developed in the 19th century, to a dominant medical model of deafness emerging across the USA and Europe. This model and the discourses it supported prioritised the learning of speech and viewed Sign Language as a deterrent to that goal. The continuation of this model today relies on a new set of tactics. This is particularly the case in the wake of the dismantling of centralised institutional spaces (schools for the deaf) traditionally responsible for the 'treatment' of D/HH children. As such it calls into question how power operates 'from a distance' (Allen, J., 2003) in the mainstream system.

Chapter 4 provided a theoretical explanation on the various modes of power to be elaborated upon in this chapter. It highlighted that they are both discursive and material in nature. It is also important to note at this point that these modes and how they are implemented are heterogeneous and context dependent, with individual differences across professionals and parents causing variation in the advice given/direction taken. However, general observations can be made indicating the maintenance of a hegemonic medical model of deafness.

This chapter examines how this hegemonic medical model is reproduced institutionally, as well as how these tactics work outside of the institutional realm. Using Allen (2003) as a guide, I examined the various modes of power at play in the mainstreamed deaf education system, concentrating on how those modes are

transformed and contextualised both temporally and spatially to provide an example of how power works at a distance. Power is examined as a combination of resources and effects (Allen, J., 2003). The concept of centralised holds of power in spaces such as institutions is rejected, and instead the ability of these institutions to pool a large array of both fixed and fluid resources is what gives the appearance of their power. As such, in this chapter the power apparently 'held' by various individuals is examined in terms of resources.

The chapter is structured around a trio of individuals and related spaces involved in maintaining a hegemonic medical model: 'expert', parent/teacher, and child. It examines how the 'expert' acts on parents to establish speech within a clinical setting; how the parent/teacher acts on the child to reproduce this decision in the home/school; and how the D/HH child internalises this process in subjectification. As such, each stage brings with it operations of power on a particular spatial level (clinic, home/school, mind/body), representing different spatial constitutions of power (institutional, dispersed, imminent). Subsequently, moving from one individual to the next involves a spatial dispersal of relations of power, with the eventual result of imminent power (Allen, J., 2003) in the case of subjectifying D/HH children.

Each stage also involves a particular goal for the reproduction of a hegemonic medical model of deafness. In the first stage, speech is established as a preferred option for communication. This largely takes place in an institutional setting through direct encounters between parents and experts. The second is the legitimising and extension of the speech route beyond institutional spaces brought about by subjectification of parents and the domination of teachers and the subsequent spreading of medical goals to both the home and the school. In this second stage, proximity to 'experts' is lessened as we move away from the traditional institutionalised power relations in the mainstreaming process. The third and final stage is the subjectification of D/HH children, whereby through self-discipline, D/HH children will come to monitor their own actions thus maintaining a hegemonic medical model. If this subjectification is successful, power becomes imminent and interaction between experts in traditional institutional spaces is unnecessary. The

medical model is internalised and the power relations necessary for its production are given temporal and spatial limitlessness. In summary, the role previously held by institutional spaces in the ‘treatment’ and ‘normalisation’ of D/HH children has been dispersed and extended in the mainstreaming process into every aspect of the child’s life through establishment of speech as a goal within the clinic, the subjectification and medicalization of the family and the school, and the subsequent subjectification of the D/HH child.

Modes of Power I: the ‘Expert’, the Clinic, and Establishing Speech as the Preferred Option.

Since the 19th century, speech was established as a viable and preferred option for D/HH children, a move which came as part of a larger scientific system engaged in the normalisation of bodies. This was accompanied by a negative discourse of Sign Language, framing it as a deterrent to acquiring speech. Doctors were the chief individuals responsible for identifying, categorising, and eradicating deviance among those bodies. Since then, several resources combine to support a hegemonic medical model of deafness. These include clinical training, funding, equipment for testing, government recognition, and the authority that this gives these professionals. This culminates in a vast bureaucratic structure as well as social authority which reinforces the role of various ‘experts’, predominantly medical, in ‘treating’ hearing impairment. This bureaucratic structure presents these professionals with the authority to administer and gatekeep access to services, which in turn acts as a further resource in their relations with parents, teachers³⁶ and D/HH children (see fig 7.1). Thus a cycle of resource and effect strengthens the authority of medical professionals within this system.

³⁶ In this chapter, the time teacher is used to refer to the mainstream general teacher. By and large, they are not recognised as experts in the deaf education system. Where other ‘teachers’ (i.e. those with more authority) are discussed, their background will be specified, usually that they are members of the visiting teacher service, and so are recognised as knowledgeable in the field of deaf education.

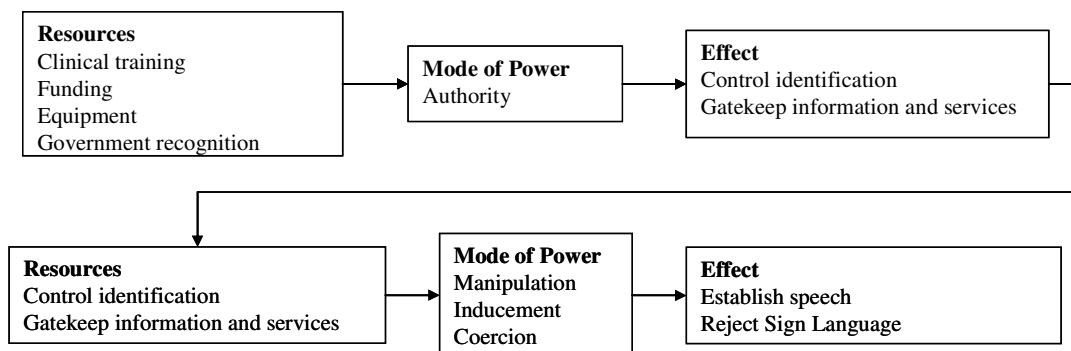


Figure 7.1 The cycle of resources, modes and effects of power at play in the clinic.

These ‘experts’ are traditionally based in institutional settings (either physical or social institutions such as hospitals, or the Department of Education and Science). They include medical doctors, audiologists, speech and language therapists, ear nose and throat surgeons, and the visiting teacher of the deaf. They are predominantly hearing, and their interest in deafness is professional. Their knowledge is often juxtaposed against that of the Deaf Community, which is viewed as personal, biased, and subjective against the objectivity and expertise of professionals (Komesaroff, L., 2008). This section is divided into two parts examining how relations between the ‘experts’ and parents play out with a clinical setting. The first part examines how speech is established as the preferred method of communication during early intervention. The second part examines how this preference for speech is retained in the face of difficulties in spoken language acquisition.

Establishing Speech: Manipulation and Gate-keeping of Information

As a result of this bureaucratic structure, medical professionals hold the valued position of being the first port of call in testing and identifying hearing loss. As a result, they provide the first interpretation of what that hearing loss means to parents of a newly identified D/HH child, an interpretation which almost exclusively relies on a medical-pathological view of deafness. This became apparent through the vast network of specialists into which the family with a D/HH child became absorbed

upon identification of a ‘problem’ with their child's hearing. Figure 7.2 below outlines the experience of two families in the diagnosis process from this research who were quite typical compared to the majority of participants. This figure shows how this process occurs over a number of precise stages, with some variation, moving up in levels of specialist training from a district nurse to an ear, nose and throat surgeon until the best means of ‘remedying’ hearing loss is achieved.

Parent 05	Parent 03
Fails 9 month check up with community health nurse	Fails 9 month check up with community health nurse
Fails second test with community health nurse at 12 months	Fails second test at 10 months with community health nurse
Audiologist in school for D/HH children confirms hearing loss at 13 months	Assessed at audiology clinic at 12 months
ENT clinic in hospital performs further test at 24 months	Assessed at ENT clinic at 13 months
Beaumont Hospital performs BSER	Severe bilateral deafness – fitted with hearing aids at 13 months
Profound bilateral deafness – referred for CI	

Figure 7.2 Diagnostic stages of Parents 05 and 03.

Since doctors and audiologists control identification, they can steer immediate service provision to support a medical model of deafness, providing an opportunity to establish speech as the preferred option during early intervention. In Ireland, when parents receive news that their child is D/HH, there are two main options from which they can choose regarding intervention and language: Irish Sign Language and/or speech. The work of the medical model at this stage is to make speech the more desirable option, and as such, seduction would be the most obvious mode of power to be employed. An important feature of seduction is that reflection and choice are present. Allen describes it as “a modest form of power which is intended to act upon those who have the ability to opt out” (2003: 31). In contrast to the force

of domination for example, through seduction individuals are led (in what seems like an independent manner) to making a particular decision. In the absence of force, decision-making processes are framed as outside of the realm of inducement or coercion, with the decision-maker seemingly consenting to the process (see chapter 4).

Initially, the task of making speech the desirable option appears straight forward since it cannot be denied that the overwhelming majority of hearing parents want their D/HH child to speak, frequently because they are hearing individuals, and view their children as part of the ‘hearing world’:

I just felt I wanted him to be more out in a bigger community instead of being in a sort of smaller community of the deaf world (Parent 02).

To view this desire for speech as a product of seduction and a relation of power, however, might be to overextend this analysis and therefore “lose what is specific to power and its modalities” (Allen, J., 2003: 99/100). Parental choice for speech at this early stage is frequently a product of their wanting the same for their children as they have themselves, though this wanting arises from the belief that to be hearing is better than to be deaf. It is not, therefore, a product of the influence of medical professionals but rather a result of larger societal norms. However, it became apparent during interviews with parents that it was not merely a matter of ensuring that parents chose speech, but that they chose speech *over and instead of* signing. This is reminiscent of Baynton’s observation that the debate is rarely about whether or not speech should be taught, but about the role of Sign Language (Baynton, D.C., 1996).

Reinforcing speech as the sole method of communication moves beyond mere seduction and involves a degree of manipulation through gatekeeping access to information and services. It starts with the early intervention services provided after identification, coordinated through the Department of Health and Children. Parents are immediately (often automatically) provided with speech-oriented services, such as provision of hearing aids, referral for cochlear implantation, and speech and

language therapy³⁷. When asked about services made available following identification, Parent 02 recounted:

we just went to audiology, and he got put on the list for speech therapy (Parent 02).

All of the parents receiving a diagnosis in Ireland³⁸ were immediately provided with hearing aids, advised regarding cochlear implantation when appropriate, and put on waiting lists for SLT. Significantly, the provision of audiology/SLT was never framed by parents in this research as a choice they had been presented with, but rather that it was an immediate, assumed 'natural' follow-on from identification³⁹. The degree of urgency and automatic provision of services supporting speech reinforces the desirability of those services, confirming to parents that this is the 'appropriate' method of treatment. In contrast to the immediacy and universality of audiology/SLT services, there was a degree of silence surrounding Sign Language use during these very early stages. The automatic provision of audiology/SLT services is not under criticism here. What *is*, rather, is the automatic assumption that *only* medical services are desired, and the manipulation of parents by withholding information on the difficulties of acquiring speech and the benefits of using Sign Language. For example, Parent 02 noted that she was not made fully aware of the difficulties in spoken language acquisition experienced by D/HH children. She recounted:

But there was nothing, you know no one sort of told you of what was ahead. You know, you were just sent home with hearing aids on and... you just have to get him talking and

³⁷While speech and language therapy services are grossly under-resourced in Ireland (O'Brien, C., 2008), thus making the 'option' of speech for D/HH children restricted in practice, the 'choice' of speech is nonetheless reinforced by professional actions and advice. As a result, this section will focus on the erosion of choice as it relates to the use of Irish Sign Language, though it acknowledges that choosing speech is not unproblematic for parents.

³⁸ A number of children involved in this research were born outside of Ireland, and received their early intervention services in their birth-country.

³⁹ One medical service always framed as a choice was that of cochlear implantation. Parents spoke of being very informed regarding aspects of the implant before making a decision. This is primarily because the surgery is so intensive, and after care requires a great deal of commitment from parents regarding frequent hospital visits.

that's it. I didn't really realise, when they give you hearing aids, you have to teach them to talk. I didn't realise that until later. I just thought, oh right, he'll probably start talking once he keeps wearing these hearing aids (Parent 02).

Furthermore, this parent (like the vast majority of parents in this research) did not receive any immediate information about the use of Irish Sign Language:

I can't even remember if they [medical professionals] even asked me 'do you want Sign Language?' They [professionals] just said, 'we'll get him talking' (Parent 02).

This omission of Sign Language as an option is a frequent occurrence. For example, in a handbook designed for parents of newly diagnosed D/HH children published by the Health Service Executive in 2006, there is almost no information provided on the use of Irish Sign Language. The ISL home tuition service is not mentioned yet there are individual sections on community audiology, the anatomy of the ear, glue ear, ear moulds and hearing aids, how to read an audiogram, and speech and language therapy. In fact, out of the ten sections in the handbook, six of them relate directly to audiology or speech and language therapy (Health Service Executive, 2006). Sign Language features briefly in a section on staff working with D/HH children (interpreters are mentioned) and in relation to speech and language therapy where "the right of the individual to develop a communication system which may include signing, is recognised" (Health Service Executive, 2006: Sheet 10).

Only one parent from the cohort of participants in this research spoke of being provided with information on ISL services immediately following identification. The ISL home tuition service was rarely promoted or even mentioned by medical professionals or those responsible for informing parents of the services available to them (the visiting teacher). Over a quarter of the parents interviewed for this study had never heard of the ISL home tuition when asked if they were availing of it. Of those who knew about the service, only two of them had been told by the visiting teacher with the remainder finding out through other networks. One parent recounted how she found out about the service through a friend of the special needs assistant caring for her son and noted:

Otherwise we wouldn't have known anything about classes or anything (Parent 09).

It would appear, therefore, that among the sample used for this research, the visiting teachers concerned were not promoting ISL home tuition. Indeed, the very nature of the ISL home tuition service suggests that it is a less significant part of the early intervention process.

As well as a lack of resources and information on Sign Language, the one service that exists is seriously neglected. There are a number of difficulties with the ISL home tuition service. There is no standardised training programme for tutors, although it is recommended that they hold the ISL certificate in teaching. Considering that they work with young people and their families in the home, it is surprising that Garda (Police) clearance is not required. Tutors must travel to the family home to deliver classes, but no allowance is given for transport. There is no register of recognised ISL tutors, and the onus is placed on parents to locate a suitable tutor. The visiting teacher, who may not have promoted the service in the first place, must sanction the service for parents to be able to receive funding. However, tutors must often work a school term in advance before payments can be made. For example, a tutor might work from September through to December without payment. Parents will then apply to the Department of Education and Science for the funding for this term. When this is received, they will pay the tutor in turn. This leads to ad hoc payment of tutors. Some parents opt to pay tutors in advance of receiving their grant, thus leaving parents financially vulnerable while they await the often lengthy remuneration process. Other parents wait to receive the grant before paying tutors for work completed several months previously. Some tutors never receive payment, with the grant being used for some other purpose by parents. Such a system would be unacceptable were it to apply to speech and language therapists, audiologists, or other teachers. The disorganisation of the ISL home tuition service points to the lack of authority given to this social model alternative to medical services. Making the service difficult to negotiate may discourage parents from pursuing it, as well as disinclining D/HH adults to work within it. It also leaves the service particularly vulnerable to criticism and prevents it from developing into a fully functioning alternative to early intervention through

speech alone. Again, Sign Language is not presented as a viable option to parents during early intervention.

Given the overwhelming monopoly of medical services, establishing speech as a preferred option can be seen as a product of the concentration of resources available to medical professionals combined with the silencing of alternative options. This concentration of resources, in a sense, empowers speech as an option for parents reinforcing it as the most desirable choice, which further aggravates the lack of resources given to Sign Language. This process leads to a cycle reproducing a hegemonic medical model (see Fig 7.3 below). In line with Allen (2003) therefore, it is not these institutions which 'hold' power, but rather their ability to pool resources, distribute information, monopolise service provision and employ various modes of power which empowers the medical model in establishing speech as the preferred option. However, there is a 'glitch' in this system, illustrated by the box on the right hand side in figure 7.3. This glitch is when parents (and children) encounter the difficulty of spoken language acquisition.

Retaining Speech: Coercion and Subjectification of Parents.

When the reality of the time and effort needed to teach speech, as well as the frustration of having a young child with whom you cannot communicate becomes a reality, this desire for speech is often diminished and replaced with a desire for meaningful communication in whatever form that may take. As parents adjust to the identification of their child's deafness, and begin to actively research communication options available to them, the possibility of Sign Language is often approached. While the majority started on a speech-only route, at least half of the parents in this research used Sign Language at some stage with their children, but frequently without the support of professional services and only to alleviate communication difficulties before spoken language acquisition occurred. Parental implementation of Sign Language (as a form of resistance) will be discussed further in the next chapter.

What I wish to concentrate on here is that, in spite of the fact that so many parents used Sign Language at some stage, the majority of them stopped and

returned to speech exclusively. Furthermore, the use of Sign Language was often on an informal basis and did not involve accessing services in Sign Language. For example, half of the parents who knew about the ISL home tuition did not avail of the service⁴⁰. One possible reason for both abandoning Sign Language and the lack of uptake of the home tuition service, even among those who knew it was available, is that there is frequently a negative discourse surrounding the use of Sign Language from medical and educational professionals. This reinforces speech as a preferred option, whereby parents, as well as not being informed about the benefits of Sign Language initially, are later steered away from its use (see ‘negative reinforcement’ figure 7.3) through the threat of negative sanctions (coercion). They are, in other words reabsorbed into the hegemonic medical model cycle.

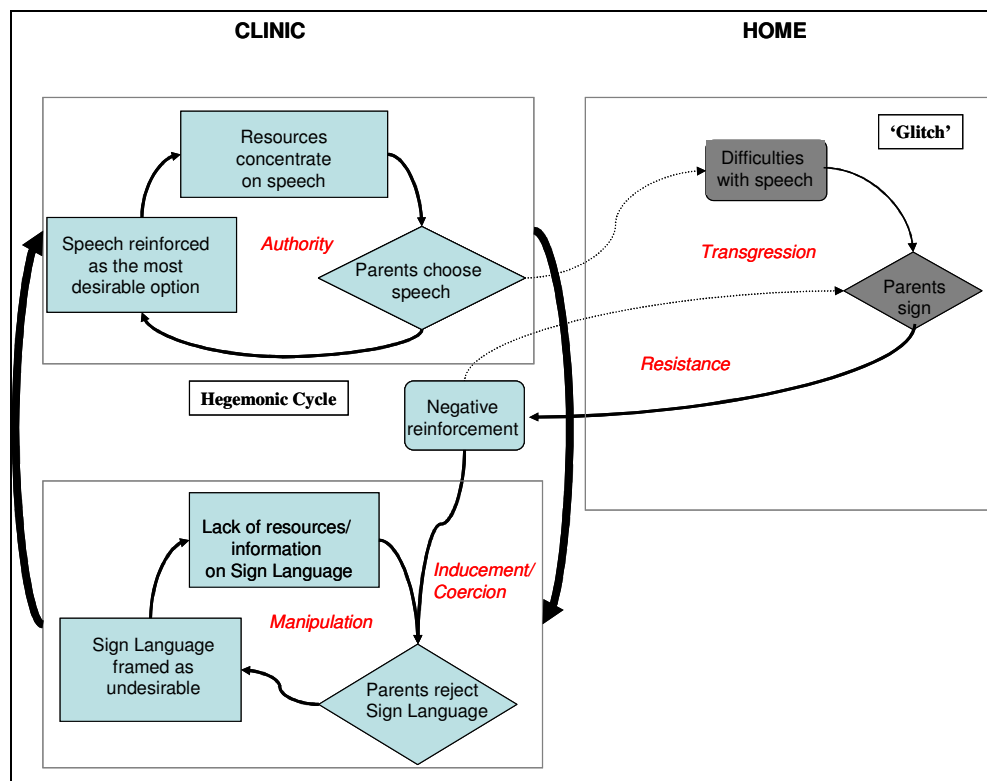


Figure 7.3 Reproducing a hegemonic medical model of deafness

⁴⁰ 6 interviewees knew about, but did not avail of the service

To steer parents away from Sign Language and back towards speech brings with it an element of force that was not apparent in establishing speech as a preferred option. As such, the mode of power implemented has a temporal aspect, with manipulation through gate keeping of information giving way to coercion over time. Parents are either won over to the advantages of their 'choice' for speech or threatened with negative sanctions and subsequently cease to resist (using Sign Language) and fall into line (Allen, J., 2003).

Often this process takes the shape of convincing parents of the practicality of speech in a 'hearing world', rewarding them with the comfort that they are doing what is 'best' for their child, and warning them of the potential consequences if they continue with Sign Language use. As Hazel's mother noted:

So they were recommending that we didn't teach Hazel Sign Language because Hazel would become reliant on sign, and where she was living in a hearing world, it was better that she develop her oral [sic] as much as possible. (Parent 17).

Two significant things are happening here: speech is being established as the preferred option for children living in a 'hearing world', and Sign Language is established as a threat to spoken language acquisition. Speech is undeniably a benefit in the 'hearing world', so once again the criticism here is not on fostering speech development, but rather on the fact that Sign Language is framed as a deterrent to that process. Sign Language was frequently framed in negative terms by medical professionals, steering even those parents who were using Sign Language away from that decision.

One case where this was evident was with Henry and his family. Henry's Mum (Parent 01) was interviewed when her son had just started primary school. He is profoundly deaf, and has other Deaf (Sign Language using) extended family members. His mother mentioned that she attended an evening class in Sign Language and used Sign Language with her son before they received a cochlear implant:

We didn't know at the stage whether he was going to get it [cochlear implant] or whether he was going to hear or what was going to happen with him. So we did a lot of sign language with him. (Parent 01).

However, when I ask whether she had availed of the ISL home tuition service she replied:

No. I didn't even know there was any. I didn't even hear that... I didn't know about that tuition. I'd like him to learn more Sign Language [for communicating with other D/HH family members] (Parent 01).

It was somewhat surprising that in a family where there were already Deaf family members and a mother paying privately to avail of Sign Language classes in the evening that their visiting teacher had not informed them of their entitlement to a weekly home visit from a Sign Language tutor. This indicates the manipulation of information at play, outlined in section one above.

I conducted a follow-up interview a year later with the same family, and was curious to see whether they had availed of the ISL home tuition service since I had last met them. She had not, her reason being:

I'd prefer to concentrate on his speech, I'd be afraid that he would depend on the signs if that was coming in. I know that he's very vocal. I would be afraid that I might regret...you know. So I'd say that his speech would be a lot better before, like he does use sign with his [other family members] but I wouldn't like for him to you know, have a tutor in signs yet (Parent 01, Follow-up).

In spite of the fact that Henry uses some signs with extended family members, his mother is still anxious that a structured programme of teaching Sign Language would in some way damage his spoken language acquisition. This anxiety is unfounded in research. On the contrary, Sign Language can foster spoken language development (see chapter 2), and is increasingly used with *hearing* children to promote their pre-verbal communication skills. Nonetheless, this discourse was common among parents, who also reported that this notion had been either instilled or fostered by the advice of professionals.

When I asked Henry's mum what the advice of the visiting teacher and the cochlear implant team was regarding the use of Sign Language and the home tuition

service, she said that no advice was explicitly given but she speculated that they would not approve:

But I'd say that her [visiting teacher] opinion would be to not go with it. I'd say she'd be happier with speech (Parent 01 Follow-up).

Either implicit or explicit disapproval from medical or educational professionals regarding Sign Language was mentioned directly by 14 of the parents interviewed and acts as a coercive deterrent to Sign Language:

Beaumont advised us to stop (Parent 04).

Well, the idea of the cochlear implant is to get them speaking. So they always, even though they do use sign through their speech therapy, they feel that speech should be their first communication (Parent 19)

She [the visiting teacher] didn't say anything but I think she didn't encourage the Sign Language, it was me asking about it. I think she felt that I was just doing it for my own benefit (Parent 10).

At the heart of this coercion is the threat of those negative sanctions, manifesting both discursively and materially (Allen, J., 2003: 31).

These sanctions were predominantly discursive in nature, and operated by creating a negative discourse of Sign Language, leading to the belief that parents ran the risk 'damaging' their child's speech by introducing them to Sign Language:

They said to me that they were against Chris getting Sign Language because he is still gaining, he is still trying to gain language [speech] and it could set him back a lot, that's what the new teacher for the deaf was telling me (Parent 02).

In line with Parent 02's experience above, Sign Language, instead of being upheld as a valuable mode of language acquisition for D/HH children, is instead labelled as a "crutch," making children "lazy" in their use of speech and causing deterioration in English grammar:

...they said she'll use it as a crutch and the less you do it [sign] she'll just have to speak (Parent 04)

I think somebody told [my husband] at some stage you know that they could get lazy using sign and that it can prohibit the speech coming (Parent 10).

[Using Sign Language], the grammar can just go straight downhill, that they just go from here (makes sloping gesture downwards), [the visiting teacher] said definitely not at the moment [...] I remember they were just saying “no Sign Language if you want to get him talking”. (Parent 02)

This causes an internalised self-disciplining among parents who wished to provide their children with the ‘opportunities’ available through speech in a hearing world and avoid jeopardising that through use of Sign Language. For example, parents 04, 07, and 12 all spoke of implementing Sign Language to alleviate communication difficulties, only to stop using it on the advice of professionals at a later date, signalling their re-entry into the hegemonic medical cycle. This process of coercion leads to the subjectification of parents, whereby they self-monitor and internalise the goals of the medical model.

Subjectification was obvious among those parents who practised a number of tactics recommended to them to help prevent signing, such as ignoring their child when they signed, encouraging them to speak instead of sign, or physically restraining themselves while they communicated with their child:

I can remember at the time being distinctly told...I was to hold my hands behind my back when I was talking to Hazel because I could not help using my hands... so the way that we were to sort of counteract that was to, when we talked to her, we found that we were using our hands, to put our hands behind our back and just, just use the verbal, rely on the verbal only. And so we did that (Parent 17).

This subjectification of parents has obvious implications for the parent-child relationship as parents take on an almost clinical role in fostering speech. This will be discussed further in the section two below.

While the discursive sanctions against Sign Language were quite explicit, material sanctions for using Sign Language were more implicit. This implicit nature is a tactic in its own right for it allows professionals to maintain an air of ‘neutrality’ that would not exist were the sanctions to be explicit, all the while parents seem very aware of what constitutes ‘appropriate’ communication. Having met with professionals over the course of my research, I am frequently reminded that they are

‘not against’ Sign Language, yet I rarely come across evidence that they foster Sign Language development with the families they serve⁴¹. One particular example of the implicit material sanction against using Sign Language is that parents seemed aware of the association between mainstreaming and speech on the one hand, and schools for the deaf and Sign Language on the other. For many, the desire to keep their child in the family home as well as promote spoken language acquisition reinforced the decision to go to mainstreaming, and subsequently for speech:

I mean the prospect of sending your 4 year old away to school is very daunting. And I mean if you live in Limerick city or if you live in Dublin, it's so much easier because they're coming home at night, but I mean if you're living here, it's boarding school you're talking about, isn't it. And it is difficult. And even a tiny, little child having to make a trip to Limerick every day from here, like it's a lot. They're tired coming home from school at 2 o'clock and they only go two miles in the road without having a big trip ahead and the early start. So that's the beauty of mainstream (Parent 18).

As a result, the lack of feasible alternative schooling options mean that speech provides access to a greater selection of local schools, while 'dependence' on Sign Language often means attendance at one of the few units or schools for the deaf across the country. There is a distinct geography to this phenomenon. Parents with greater levels of choice due to their proximity to urban areas were more likely to implement Sign Language with their children, since its use did not curtail their access to particular services. It is also possible that they were more likely to use Sign Language due to their proximity to services run by the Deaf Community, thus giving greater access to alternative discourses of d/Deafness. All of those families proactive in using Sign Language⁴² with their child lived either in or close to a city with access to a specialised programme for D/HH children.

⁴¹ There was a small number of notable exceptions. In particular, I have met a handful of teachers who have gone to great lengths not only to improve their own Sign Language skills, but to encourage its use among parents. Some of those professionals declined to take part in the research officially as a result of their approach to Sign language, which they felt would not be approved of by their colleagues, and would make them easily identified in the research.

⁴² Families were deemed ‘proactive’ in using ISL if they fulfilled 3 criteria: a) they had taken ISL classes or used the ISL home tuition service; b) they used ISL for communication at home (even if coupled with speech), and c) their children had some access to ISL in school. Using these criteria, there were 6 families in the research in this category. A number of other families fulfilled 1 or 2 criteria (often that their children had access to ISL in a unit) but frequently did not use ISL at home, specifically to foster speech.

This section discussed how the ability of 'experts' to pool resources gives rise to a 'narrowing down of options' as parents make communication decisions for their D/HH children. A realistic informed decision between viable options is not made possible. Parents are provided with automatic access to speech services, and simultaneously denied access to information on the benefits of using Sign Language. Nonetheless, it can be assumed that parents know of the existence of Sign Language and its use among the Deaf Community. However, in the absence of professional endorsement, Sign Language becomes framed as an undesirable 'safety net' option, to be implemented only if spoken language acquisition fails. As such, information is manipulated through gate keeping as parents are steered onto a speech route.

However, many parents implement Sign Language at some stage, frequently out of frustration with communication problems in the home. In a way, this highlights the spatial and temporal constitution of power, whereby manipulation and gate keeping of information may work within an institutional setting during immediate intervention stages, yet in time when parents struggle to implement speech without a network of support in the home, the desirability of speech is lessened. Thus to maintain a hegemonic medical model and non-use of Sign Language amidst the difficulties of implementing a speech-only route, coercion comes into force, manifesting in a negative discourse of Sign Language and subjectification of parents.

This negative discourse is most frequently articulated as disapproval from medical professionals regarding the use of Sign Language and the implicit or explicit direction that it will interfere with spoken language acquisition. Thus, even for those parents who saw the benefits of using Sign Language, the threat of damaging their child's spoken language acquisition frequently deters them from continuing with Sign Language. The combination of discursive and material sanctions for signing meant that many of the parents, while they may have used some Sign Language initially, eventually implemented a speech-only route, re-entering the hegemonic medical model. This subjectification of parents allows power to operate at a distance, with the medical goal of establishing speech internalised in parents and thus carried out of institutional settings, spreading into the home and eventually

school. At this stage, a new set of power relations come into force as parents implement a speech only route with their children. While the first stage involves convincing parents of the necessity of speech, the second stage involves encouraging children onto a speech only route.

Modes of Power II: Parents/Teachers, the Medicalization of Home/School.

The establishment of speech as the preferred option for communication, as described above, is largely instigated in institutional settings and involves direct encounters between 'experts' and parents. Actual contact between D/HH children and 'experts' as the child acquires language however, is quite limited. As a result, much of the process of spoken language acquisition takes place at a distance from institutional settings. In this context, one of the greatest identifiable strengths apparent to the medical model is that its authority extends beyond the medical arena to create a plethora of *medicalised* spaces. Through the subjectification of parents and the domination of teachers, the goal of medical institutions is carried beyond the institution itself as parents and teachers adjust their relationship to D/HH children accordingly. Within this framework, the home and school become spaces wherein D/HH children are continually subject to medical interpretation.

The operation of medical authority at a distance is a crucial component of the mainstream education system. Traditionally, D/HH children would have attended a school for the deaf from an early age where they were subject to close and continuous monitoring by staff specialising in deaf education. In the mainstream system, such traditional avenues of power relations between professionals and D/HH children no longer exist and are, instead dispersed into a network of *medicalised* spaces using parents and teachers as intermediaries between the 'expert' and child. This section will examine how, first of all the home and later, school become *medicalised* and the subsequent impact on parent-child and teacher-child relationships.

The Medicalised Home

The first case of medicalised spaces is the extreme and explicit medicalization of family life, where the domestic environment becomes a site for the continued 'treatment' of D/HH children. While concepts of 'home' have long been the focus of feminist, and feminist geographical discussion, they have been revisited in recent years (Blunt, A. and Dowling, R., 2006), with particular examination on how home is both spatialized and politicised. Home, according to Blunt and Dowling (2006), does not simply exist, but rather is made through social and emotional relationships. As such, 'home' is imbued with particular norms of (among others) heterosexuality, ability, childhood and class. Blunt and Dowling (2006) address this reproduction of norms by looking at the intersection between home, power and identity. In the case of D/HH children, the experience of home may be influenced both by their status as child and as deaf/disabled, both positions identified in the literature as problematising adult-centric and ableist concepts of home spaces (Oldman and Beresford, 2000; Wood, D. and Beck, R.J., 1994). As a result, there are ramifications for how 'home' might be experienced when used as a medicalised space of rehabilitation.

This medicalization of the family home is addressed in Foucault's (Foucault, M., 1980) *The Politics of Health in the Eighteenth Century*. Citing childhood as problematic, it is the family which becomes the pivotal source of securing the production of healthy children, as set down by the (Medical) State. Foucault (1980) refers to this move as "the privilege of the child and the medicalization of the family" (1980: 96). The family environment

is no longer to be just a system of relations inscribed in a social status, a kinship system, a mechanism for the transmission of property; it is to become, a dense, saturated, permanent, continuous physical environment that envelops, maintains, and develops the child's body (Foucault, M., 1980: 96)

As such, the health of children becomes "one of the family's most demanding objectives" (Foucault, M., 1980: 97).

This child-centeredness of the family home revisits Foucault to frame the family home as a space where opportunities for 'appropriate' development of

children can occur. It is the hearing family, through the advice of medical and education professionals that steer the 'healthy' development of D/HH children. 'Healthy' under this model means returning D/HH children as close as possible to the hearing 'norm', for it is their deviation from that norm that jeopardises their development. There were numerous examples in the research of how the rehabilitation of D/HH children means that the family home becomes a site for medical treatment. Two such examples include how the home becomes an extension of the audiology clinic through what I refer to as the 'hearing aid routine,' and the practice of speech and language therapy within the home.

As noted already, following identification D/HH children are fitted with hearing aids to provide access to sound. This access to sound, however small, allows for neural pathways in the brain to form which can act as a basis for later audiological treatments, in particular cochlear implantation. Lack of access to sound will mean that any later attempt at rehabilitating hearing will be fruitless because of the absence of neural synapses dedicated to hearing. Subsequently, it is advised that children wear hearing aids during their waking hours, and the necessity of this is stressed to parents. Ensuring that this happens provides an example of medicalization of the family home. It was an issue which most parents spoke of as resulting in (sometimes comical) difficulties for them:

She'd just keep throwing it [hearing aid] off, and she'd laugh at me. And I'd be chasing her and have to put the baby down. This was her way of getting me to put the baby down, as devious as you like. So she'd run towards the bathroom with this hearing aid and, oh merciful god, and the baby had to go and she had to be sorted, so it was a game (Parent 12).

I think he got his first aids at seven or eight months maybe, and we went through the stage of him pulling them out and eating them and throwing them at the dog and the whole lot (Parent 10).

[We] got the hearing aids which were absolutely no benefit to him whatsoever. He couldn't hear anything with them. He kept putting them down the toilet, throwing them in the fire (laughs) he used to do everything (Parent 07).

However, owing to the subjectification of parents (see section above), their investment in the advice of medical and educational professionals and their desire to improve the chances of spoken language acquisition, they will persist with

something which appears to them to be of little benefit (Parent 07 above), and even with something that often noticeably aggravates their child (Parent 02 below). For D/HH children, this encounter with their parents can be experienced in a variety of ways. It is occasionally manifested as domination, with force coming into play. Henry's mother spoke with distress recalling how she would struggle to ensure he wore his hearing-aids at all times:

Now when he wore hearing aids it was such a pain to get them into his ears. He was screaming and was so young, like one and a half year old. You're like, 'Oh I'm so sorry' (Parent 02).

For others, inducement came into play whereby children were rewarded for wearing their hearing aids:

so then we explained to him, you know, 'these are going to let you hear, and play with your friends', and he never had any problems. He put them in before he got his breakfast, before he got dressed, before he got washed, before anything, and he took them out at the very last thing he did at night (Parent 21).

This hearing aid routine is complemented by intensive speech and language therapy (SLT) that parents conduct with their children in the home. Due to the sporadic and scant access to a qualified therapist in Ireland, parents frequently receive training in therapeutic practices that they can conduct with their children, most often at home. In some instances, enrolment on a course for parents is a prerequisite for children to receive speech therapy. As such, the home becomes clinic and child-parent interactions become framed as opportunities for SLT. This practice of parents providing a form of speech therapy to their children is common, as the world-famous John Tracy Clinic illustrates with its manifesto which states that "[t]he main focus is on educating the parents, as Mrs. Tracy felt from the start that in order to help children who are deaf, we must help their parents" (John Tracy Clinic, 2009: 2). This provides a clear example of how 'experts' use their authority to work on parents, who in turn work on children. Several of the families in this

research had completed the correspondence course available through the John Tracy Clinic, and one family had travelled to California to attend the clinic in person.

Others availing of local services reported having to complete similar courses before their children could receive SLT. Therefore, while access to a qualified therapist is sporadic and unreliable (see chapter 6), many parents had received instruction either from a SLT centre, their visiting teacher, or through the correspondence course and were able to work at home on speech acquisition:

[Access to a therapist] is usually half an hour [...] and then we get a lot of stuff to do at home, you know. We get a lot of sheets and stuff to try and do. And we did a postal thing with the American [John Tracy] clinic, they send you activities. So we knew quite a lot, what activities are involved (Parent 02).

Echoing Foucault, this period of childhood becomes particularly crucial (see Parent 10 below) in the 'appropriate' development of the child with the responsibility shifting often to the mother to undertake this work:

[The speech and language therapist] knows he is priority, because he's at this vulnerable stage. But I found her very informative. She gave me specific exercises to do [...] the objective now is for him to learn 5 action words for January, and she told me they're going to be "running, sitting,..." and you can expand on them. She was very good, she told me exactly what to do with him (Parent 10).

For the parents quoted above, as for most parents in the research, this work on speech was a significant part of their daily routine. Other parents recounted:

So I would say, em... oh a good hour a day and a few at the weekend, definitely. (Parent 11).

We'd had virtually constant speech therapy going on in this house, in the mornings and night (Parent 21)

For some, it became a particularly arduous task with little reward:

We still had to sit with him every day. We would sit him down for an hour every single day and do the speech therapy with him, the stuff that [the visiting teacher] was giving us and the stuff that Beaumont [Hospital] gave us and it just seemed so frustrating, we were making, it seemed that we were making no progress. But we just kept going and kept going, we were determined. They kept saying "just keep doing it, keep doing it", we were like, "we're getting nowhere!" It was heartbreaking even taking him in if all the kids were outside playing and, you know taking him in and making him sit down on a summer's day, like even right through the summer and everything we made him sit and do the work. (Parent 07).

Again, the issue of subjectification of parents is apparent as they pursue a medical goal through difficult situations.

For children in this situation, their experience of home is altered since it becomes (for some time on a daily basis) an extension of the speech therapy clinic and the work of the visiting teacher, extending into the summer when other children are off school. Relationships with siblings were also altered, which became particularly apparent when there were two D/HH siblings in one home. When asked about communication between her D/HH son and D/HH daughter, one mother noted:

Mother: She [Ellen] spends a lot of time with Chris which is not great because sometimes they are both just pointing and doing this sort of stuff (gestures)

Elizabeth: can they communicate with each other?

Mother: yeah, they are very close...

Elizabeth: and do they both use speech together?

Mother: yeah they do, I mean, I ... Chris and Ellen do, but I've noticed sometimes with Chris that he doesn't and they are both sitting out there in the garden quietly just pointing at things and going like this (gestures then laughs). And we say 'hey Chris you have to keep talking to her' but his speech isn't perfect by any means. So that's tricky, it is difficult (Parent 02).

During my interview with the children mentioned above (Chris and Ellen) it became apparent that gesture and elaborate pantomime were important parts of their communication system, although the family were implementing an oral-only policy and had rejected the possibility of Sign Language on the recommendation of their visiting teacher. In an environment where immersion in spoken language is encouraged, the presence of a D/HH sibling creates a difficulty, whereby an

appropriate language model is absent. For some children this provided an opportunity for resistance, an issue which will be discussed in the next chapter.

This promotion of speech is accompanied by tactics to discourage Sign Language (or even gesture). Having been induced or coerced away from Sign Language by 'experts' within a clinical setting, parents in turn use a variety of tactics to discourage their children from Sign Language use. Just as doctors use the resources such as funding, clinical training and the ability to gatekeep access to services, parents use resources available to them, in particular the ability to grant or deny desired objects to encourage children to speak:

The minute she was implanted we had to stop signing, well we didn't have to but Beaumont advised us to stop... it was terrible ignoring her ... you know she'd ask me for a drink [demonstrates sign] and we were like 'ah, what? I can't hear you.' Ah, it was horrible (Parent 04).

Essentially, a process of discouraging one language (negative reinforcement) while encouraging the other (positive reinforcement) takes place (see figure 7.4 below). The issue of positive reinforcement of Sign Language use, giving rise to resistance, will be discussed in the next chapter.

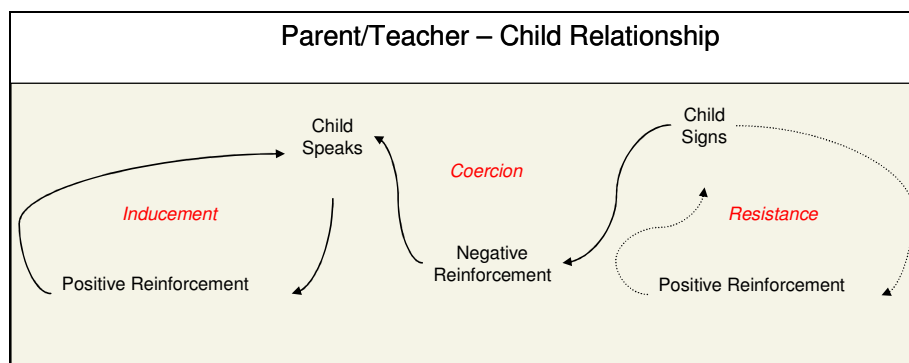


Figure 7.4 Promoting spoken language in the (medicalised) home/school

Home, as such, becomes a site where the goals of medical institutions are played out. While resources are mobilised within institutional settings to convince

parents of the value of medical goals, the effects of this encounter are played out at a distance in the home. Parents, in turn, use their own resources (status as parent, fluency in speech, authority over children, ability to grant/deny desired objects) to achieve hearing aid use and encourage speech. The result is that D/HH children are subject to the clinical gaze in the family home, with everyday interactions between parents and siblings being framed as opportunities for rehabilitation. Frequently, the role of parent becomes akin to that of medical practitioner and educator combined, where all opportunities are seized to encourage the 'healthy' development of language

These encounters also illustrate the translational qualities of power (Latour cited in Allen, J., 2003) where individuals shape the process as it is played out, from 'expert' through parent to child. It also highlights how the goals of medical institutions can be achieved at a distance through subjectification. These encounters are temporally specific, particularly found in early childhood, following identification and before children start school. At the commencement of school, however, this practice is extended to the classroom also, with home, school and clinic working together in the rehabilitation of the D/HH child.

The Medicalised School

The medicalization of the school system is clear from the outset given that hearing impaired children are defined (within mainstream education services) as:

such pupils [who] have a hearing disability that is so *serious* to *impair* significantly their capacity to hear and understand human *speech*, thus preventing them from participating fully in classroom interaction and from benefiting adequately from school instruction. The great majority of them have been prescribed *hearing aids* and are availing of the services of a Visiting Teacher. (This category is not intended to include pupils with mild hearing loss) (Department of Education and Science, 2005: 17 my emphasis)

Deafness is defined as the inability to hear and understand *speech*. No reference is made to the inability to hear other environmental noises, nor to the use of an alternative, visual means of communication which could overcome this barrier to participation in the classroom. Again, there is specific mention of the use of hearing

aids and there is an overall assumption that speech will be the main mode of communication for the D/HH child in mainstream placements. As such, the school becomes not only a site of education, but education through a particularly normalising lens where the D/HH child must first learn to communicate through hearing and speech before they can proceed with the mainstream curriculum.

In addition to this, the mainstreaming movement is relatively new in Ireland and teachers often lack the experience in dealing with particular disabilities, especially in the case of low incidence disabilities such as deafness. For many teachers, this may be the first D/HH pupil they will have had in their class. In the absence of their own expertise, teachers rely on the guidance of others and follow their instructions quite routinely. Often, this instruction comes from the visiting teacher service. As a result, unlike parents, where the goal of spoken language acquisition becomes internalised through subjectification, teachers are more likely to simply follow a line of command, even if it is in spite of their better judgment. As a result, while the medicalisation of the home relies on the subjectification of parents, domination is a more common strategy among teachers in mainstream settings. They receive orders (although this maybe framed as advice, guidance, help) from 'experts' in authority, in particular speech and language therapists and visiting teachers. This makes the mainstream classroom a particularly fertile ground for the use of authority. The medicalisation of the school environment will be examined in this section as it relates to establishing speech as a goal to be pursued by school staff and the correlating absence of Sign Language.

The oral environment of the mainstream school meant that it was frequently seen to complement the work taking place in medical institutions and the medicalised home. This is in spite of obvious difficulties in communication with young D/HH children in mainstream settings. Due to the D/HH child's delayed (spoken) language acquisition, and the exclusive use of speech for communication within classrooms, communication was cited as problematic by a number of teachers:

His speech was the biggest problem when he started here [...] Most of the time, unless it was something that is very much in context, I couldn't understand him at all (Professional 11, mainstream teacher).

She had very, very little speech... and I found it very hard. I find it very hard to understand what she was saying (Professional 16, mainstream teacher).

Nonetheless, or perhaps as a result of these difficulties, fostering spoken language development becomes a priority of the mainstream environment, carried out through teachers, resource teachers, special needs assistants, as well as hearing peers who provide immersion in a spoken language environment. This priority became apparent when teachers spoke of their role in the classroom, especially those teaching younger children:

my role was to develop his oral language (Professional 12, resource teacher).

I would have done work as well as his speech therapist, like whatever she does on Friday I'll go back over it. I kind of do it for the week and then we send it home as well (Professional 13, unit teacher).

I found it great because the speech and language therapist would tell me what programmes she was working on, she would give me what she was doing and I'd photocopy it give it to the parents. So there were three of us [speech and language therapist, parent, teacher] working on it (Professional 10, unit teacher).

The comments from professionals 10 and 13 in particular highlight the impact of clinic, home and school all 'working on' the D/HH child. As such, the school in its medicalised form takes on a particular function in the rehabilitation of D/HH children. This was particularly clear in the case of Grace, a seven-year-old deaf girl attending a unit for D/HH children for whom speech, rather than education became the priority of her school.

Grace received a cochlear implant when she was three years old. However, the cochlear implant team has recently recommended that Grace be removed from the unit and mainstreamed full-time. Her teacher noted:

Teacher: they [cochlear implant team] recommended that she be in mainstream [...] because the brain shuts down to language acquisition at seven, they want them as much as possible in - in mainstream ... so that was her reason for ...

EM: okay it's really for speech development then?

Teacher: it's for speech development yeah

EM: okay, do you think would her educational development be?
Teacher: oh it would suffer greatly (Professional 10 – unit teacher).

This indication from the unit teacher that the mainstream school environment was seen as ideal for fostering spoken language development was supported by the interview with Grace's mother:

They want Grace to be mainstreamed so that the implant will work for [her]. ... because at that age, they believe you will pick up more Sign Language. Because the emphasis of the implant, if they are doing the implant they won't want you to sign (Parent 15).

Moving Grace out of the unit and into the mainstream is not only to encourage speech but also, as noted by her mother above, to avoid the Sign Language which is being used in the unit. The teacher in the unit has worked with D/HH students for quite a number of years and has a basic level of Sign Language as a result. A number of children in the unit are Sign Language dominant (using it instead of speech). For Grace, mainstreaming (and speech) is contrasted against the unit (and Sign Language), a feature which was found in a number of other participants:

Parent: You see that's where I'd be afraid [with the unit] - the sign.
EM: Yeah, what would you be afraid of ?
Parent: My main worry there - my main worry would be none of them are speaking properly
EM: Mmm
Parent: So how can they learn from each other? Like Marie has learned loads from me - loads from Beaumont, but mostly what she's learned is from her friends
(Parent 04).

We did look into sending him to the deaf school in Cabra. A lot of that is based on Sign Language. They would teach you Sign Language and speech. It was our own decision. We said 'Oh, no'. I felt that maybe if he went to somewhere where he would depend more on the Sign Language then his speech wouldn't come along as much (Parent 01).

Thus, similar to the parent-child relationship discussed above (figure 7.4), teacher-child interactions are dominated by spoken language, and are characterised by a lack of Sign Language.

The latter is particularly the case since so few teachers have Sign Language, making it an unfeasible alternative to spoken language communication within the

classroom. Hearing teachers in mainstream schools⁴³ are not obliged to have Irish Sign Language to work in this profession, nor are qualified Irish Sign Language interpreters provided in schools. While several teachers may take some evening Sign Language classes (usually only a basic level) they would by no means qualify as Sign Language role models to the extent that native/fluent signing D/HH adults would. As a result, the use of Sign Language where it occurs in mainstreaming tends to be tokenistic and greatly limited to the haphazard training acquired by hearing teachers. One teacher working with several D/HH pupils noted (rather diplomatically) that there was “no pressure to sign or speak”, meaning that children could use either form of communication. However, since she doesn’t have Sign Language, her pupils must communicate in speech if they wish to talk directly to her. She continued:

I suppose that’s one thing that’s quite unusual like, I got the job and I can’t sign...but I don’t need it as much and I’m very thankful that I, you know, I don’t actually need it, because James is speaking as well, if not it would be desperate, you know, I’d have to learn, I’d really have to learn if I was in a class where a child just signed, you know (Professional 13)

This observation (that she doesn't need Sign Language) is in spite of the fact that she noted earlier in the interview that she sometimes struggles to understand her pupils’ speech, that they misunderstand her, and that she relies on the SNA (a Deaf adult with Sign Language) to provide interpretation from time to time. The absence of Sign Language role models within mainstream classrooms (with the exception of the few Deaf SNAs employed across the country) adds to the medicalization of the mainstream environment by denying those children who have some Sign Language (from its brief implementation by their parents as highlighted above) the opportunity to use that as a mode of communication.

⁴³ Hearing teachers working in schools for D/HH children, where a qualification in deaf education is required may also be obliged to have an ISL requirement. For example, those completing the PGCE in Deaf Education through a distance learning programme with Birmingham University are required to complete the Signature (previously Council for Advancement of Communication with Deaf People – CACDP) level 2, which is described as a level of functional ISL equipping people to deal with routine language tasks. While this displays a level of sign competence, it would not bring teachers to a level where they could model language excellence for D/HH acquiring Sign Language.

Overall, Grace's placement was guided by the medical pursuit of speech regardless of the educational impact, as her unit teacher noted above commenting that it would "suffer greatly". As a result of a medical report, she is now allowed a maximum of two hours a day in the unit for D/HH children with a teacher who uses both speech and signs. The rest of her time is spent in the mainstream classroom. Removal from the unit has a number of consequences. Since she is no longer registered full-time with the unit, and since she is travelling out of her catchment area to attend the school, she runs the risk of losing the transportation provided to bring her to the school, which is sanctioned because she had been attending the unit. This would also involve her being separated from her brother, who attends the unit full time and has transport sanctioned as a result.

For Grace, leaving the small numbers of the unit to attend a mainstream class where she does not follow what is happening is a cause of distress, and her teacher reports that she frequently cries when leaving the unit to return to the mainstream class. The unit teacher spoke candidly about what she felt was the inappropriate placement of Grace in the mainstream, in particular the emotional distress it caused, the implications it had for her resources, and her inability to follow the curriculum in that environment. Nonetheless, she also noted that "it's the [medical professional] is the one that has the say, not the teacher" (Professional 10 – unit teacher). Therefore, while teachers may not be subjectified, in that the medical goals they carry out are not always internalised, they must follow direction as it is passed down through a system which favours medical professionals, resulting in a top-down domination which allows little (though some) room for manoeuvre, and the overall medicalisation of the school environment. Some instances of resistance will be discussed in the next chapter.

While Grace continues to use signs with her deaf sibling and classmates in the unit, the children and teacher in her mainstream class do not have Sign Language, nor does her mother. As a result, the ability to fully acquire Sign Language is also diminished due to the absence of suitable language role models. For Grace, both home and school lives are encouraging spoken language acquisition, with each becoming part of the institutionalised 'treatment' of her

deafness. This process, in Holt's terms can be understood as part of an "institution, which operates within and between schools" (2003: 122). Holt continues that this process is

institutionally ableist, being underpinned by the assumption of a 'normally developing child', and locating any 'deviation' from this norm within the individual child, rather than examining socio-spatial processes of disablement in schools (Holt, L., 2003: 126).

In other words, Grace's schooling is driven by an institutionalised medical model of deafness. It does not seek to adjust the educational environment to meet her needs but rather, it uses the educational environment as an opportunity for medical intervention and normalization.

The ability to mobilise parents and teachers to work on the medical goal of achieving speech is an effect of resources available to medical professionals. In turn, this allows for a hegemonic medical model of deafness to be reproduced at a distance from institutional settings in the current system. This means that the establishment of speech as the preferred language of communication is secured through the authority of medical professionals as they influence parental behaviour during early intervention, and as parents make educational decisions for their children. It is continued through school spaces with the bureaucratic authority afforded to medical practitioners (such as psychologists' reports) in educational policy. However, the reproduction of a hegemonic medical model of deafness beyond early childhood relies on the actions of D/HH children themselves, as their own process of self-identification matures. This leads to the final tactic of power to be discussed here: subjectification and D/HH children.

Modes of Power III: Subjectification and D/HH Children

As outlined above, the extension of medical spaces to the domestic and educational environments relies on subjectification of parents and the domination of teachers. In turn, parents and teachers use their authority over D/HH children to promote the medical goal of spoken language acquisition. This has profound impacts on the D/HH child, in particular his/her ability to identify as D/HH in a system which

endeavours to erase that characteristic. The result is a process of the subjectification of D/HH children, the third stage in reproducing a hegemonic medical model of deafness.

Foucault describes subjectification as the way a human being turns him- or herself into a subject, their tendency to view themselves as others see them (in Rabinow, P., 1984). For D/HH children, this involves viewing the D/HH 'self' as 'other' and the hearing 'other' as 'self'. As such, outward appearance (how you speak, gesticulate, perform on audiology or verbal ability tests) reveals deafness. Instead of being viewed in a positive light (as in Deaf Culture), these acts/traits are pathologized and distanced from the 'self' as being 'other', 'deviant', 'abnormal'. The goal therefore is to externalize the hearing 'self' and eliminate the deaf 'other'.

While this is not explicitly stated as a goal of education, it can be observed in the current system, in particular when working on speech becomes a priority of the education system. To examine this process, I will reflect on the stages outlined by Foucault in his examination of Pinel's treatment of psychiatric patients: silence, recognition by mirror, and perpetual judgement. Allen (2003) has identified Foucault's lack of specificity to the various modes of power as one of his weaknesses, I would argue that, while not explicitly discussed as modes of power, Foucault makes reference to a number of different tactics which could be recognised as ways in which power operates. The three stages of treatment listed above are used as examples in this section. While Foucault's study was in relation to madness, similar tactics in the treatment of D/HH children emerged. Indeed, the physician at the heart of Foucault's study (Pinel) was a mentor for Itard (who later was responsible for the instigation of the medical discourse of deafness) during his professional training (see chapter 5). Many of the features of silence, recognition by mirror and perpetual judgement have been discussed in the previous two sections but will be drawn together here as they relate to the overall subjectification of D/HH children.

The first, silence involves denial as a mode of power, where cultural Deafness is not recognised. According to Foucault, the essence of silence is to instil

in the patient a sense of guilt of his own condition through ending all communication regarding (in Foucault's case) his madness: "the language of delirium can be answered only by an absence of language, for delirium is not a fragment of dialogue with reason"(Foucault, M., 1965: 152). In the case of D/HH children, it ends communication regarding their deafness. This process of silencing operates on two levels within the mainstream system. On a macro systematic level, the absence of both Sign Language and D/HH adults in the mainstream education system (see section two above) leaves D/HH children little option but to use speech and attempt to perform akin to hearing children if they are to proceed through this educational setting. Furthermore, the lack of preparedness of mainstream teachers for the complexities of educating D/HH children, as well as the difficulties (highlighted above) in communication experienced in the classroom means that the specific needs of these children may go unmet. At the micro level, the silencing of Sign Language by 'experts' in early intervention (see section one above) and the subsequent silencing by parents of Sign Language within the home (see section two above) mean that children are raised in an environment which prioritises spoken language acquisition. Examples have already been given in relation to these. As a result, processes of silencing taking place on a systematic level (through the exclusion of D/HH teachers and the absence of Irish Sign Language in the curriculum) are accompanied with processes of silencing as parents and teachers encourage speech.

The combination of micro and macro level silencing indirectly subjectifies D/HH children, by creating an environment exclusively informed by a medical view of deafness wherein they are given little option but to identify as 'impaired'. If Sign Language *is* provided, it is often rescinded later. Following this its use is ignored, discouraged or even punished. As a result, the child's Deafness (practised through his/her use of Sign Language) is not encouraged, but rather erased in the process of rehabilitation, a process which progresses to the second stage of subjectification, recognition by mirror.

Recognition by mirror, is outlined by Foucault as a disciplinary technique whereby "madness would see itself" and would begin to view itself as others view

it. For D/HH children, viewing themselves through a hearing lens contributes to their subjectification. For children in this process, they do not recognise their Deafness from a cultural perspective but rather experience it as a stumbling block between them and their hearing identity.

The process of recognition by mirror can be seen in an explicit way when one reflects on the practices of oralism with D/HH children. The use of actual mirrors in speech and language training can be seen as more than simply a tool used for the visualising of mouth shapes. Mirrors are combined with audio equipment which allows D/HH children to hear their own voice and compare it against the hearing model (see plate 7.1 below). They also encourage D/HH children to enter that process described earlier of externalising the ‘hearing’ self within, encouraging them to monitor how they look and sound while they speak and align this to the hearing norm.



Plate 7.1 Recognition by Mirror.

Source: <http://www.newpaltz.edu/newspulse/1009/> accessed 6-6-10

Examples of self-consciousness of D/HH children, in particular how their deafness was viewed by their hearing peers, were evident in this research. From reports of parents it seems that some D/HH children had already begun to internalise this expectation of conforming to hearing norms, in particular as it related to their speech, use of hearing aids, and the presence of D/HH adults. Henry was five years

old and according to his mother (quoted below) was showing signs that he had internalised the gaze of his hearing peers:

Because one thing that Henry finds really hard is to speak in front of the rest of the students. I think he's wary of the fact that when he speaks that his words aren't as clear as all the other students. I think he knows like. So...he wouldn't speak in front of them (Parent 01).

Chris, like Henry was reluctant to have his peers notice signs of his deafness, in this case his hearing aids:

Chris is conscious of his hearing aids because he's growing his hair at the moment so you can't see them now (Parent 02).

Of course, self-consciousness among young people is a common trait, as is comparing themselves to their peers. However, for D/HH children this process is complicated by the medical gaze which leads them to compare themselves to an unachievable norm. There are, of course, instances of self-consciousness among some D/HH children which are not reflective of this medicalised process.

For example, Áine is older than Henry and Chris and identifies as Deaf, attends a unit for D/HH children, uses ISL for communication and has Deaf friends. For her, her self-consciousness of her d/Deafness is for different reasons and she has decided against getting a cochlear implant because it does not fit with her Deaf peers. Her mother noted:

But Áine doesn't want it now. She doesn't want the operation. It isn't so much, she isn't really afraid of the cochlear implant as such, but it's the operation, going through all this that she doesn't want. And then they do see at the summer camps, this [the plastic receiver behind the ear] falling off as they say (gestures implant falling off side of head). Sure that could happen any hearing aid! She just doesn't want one, and then like because Jane and Moira don't have them, even though the two boys have them in the school, but they don't have them, and I think they're happy enough to go that way. (Parent 03)

While Áine demonstrates resistance to subjectification it became apparent that, even among this group of D/HH young people, their self-consciousness about deafness was apparent.

In a focus group interview with Áine and two of her friends, they spoke of their awkwardness around culturally Deaf adults who used a lot of facial expression with their Sign Language:

Moire: IN⁴⁴ DUBLIN THEY [DEAF PEOPLE] USE A LOT OF FACIAL EXPRESSION. I HATE THAT!
EM: WHY DO YOU HATE THAT?
Moire: BECAUSE IT'S TOO... IT MAKES ME... IT'S VERY NOTICEABLE. WITH LIPREADING YOU NEED A (CALMER) EXPRESSION, I LOVE TO BE ABLE TO LIPREAD, TO FOLLOW WHAT'S HAPPENING ON THE MOUTH
EM: SO FACIAL EXPRESSIONS YOU DON'T LIKE, WHY DO YOU NOT LIKE THOSE, HOW DO YOU THINK THEY LOOK?
Moire: THEY JUST LOOK WEIRD TO ME.
(Focus group with D/HH youth)

While part of Moire's dislike for facial expressions is that it interferes with her preferred method of communication (a combination of lipreading and Sign Language), she is also concerned how noticeable it is and about how they look, indicating that she may be viewing herself through the eyes of hearing peers.

Silence denies D/HH children the opportunity to identify as Deaf, while recognition by mirror ensures that they view themselves through a decidedly hearing lens. This process is reproduced and reinforced by the presence of perpetual judgement (the third stage) which disallows the 'patient' from escaping this objective view of self as 'other'. In relation to madness, Foucault states "[b]y this play of mirrors, as by silence, madness is ceaselessly called upon to judge itself" (Foucault, M., 1965: 154). Similarly, with the medicalisation and treatment of deafness through oralism and conformity, the D/HH person is constantly in a process of self-monitoring, thus ceaselessly called upon to judge themselves.

Living in a so-called hearing world, the D/HH child is called at all times to assume a 'hearing' appearance. The attention calling techniques (waves, shouts,

⁴⁴ This all-caps font is used to denote that the text is an English gloss (translation) of Irish Sign Language.

banging on a table to issue vibrations) and communication methods (Sign Language) that have emerged within Deaf Culture are not welcomed by this perpetual judger. Perpetual judgement, therefore, marks the progress from externalised discipline through silence and recognition by mirror to internalised control, whereby the D/HH child through the direction of 'experts' and parents/teachers will self-regulate, self-discipline, and conform to set goals. This allows for the hegemonic medical model of deafness to continue indefinitely, transcending spatial (institution, home, school) and temporal (childhood) boundaries.

Perpetual judgement as an effect can be seen in the reluctance of D/HH children to embrace aspects of Deaf Culture even when they are presented as an option. In one unit I visited a Deaf SNA works with the hearing teacher among a group of D/HH children. Since several children struggle with spoken language acquisition, this SNA was employed to provide assistance in communication through Sign Language. Providing access to a Deaf role model who was a fluent Sign Language user should provide an opportunity for an alternative identification of Deafness for these children. However, in conversation with the SNA, she commented on how her D/HH students rejected her use of Sign Language in the classroom. My notes from that meeting read:

Both of the students respond very well to spoken language and seem to reject the presence of Sign Language in the class. Orla [SNA] is not quite sure why this is. It may be that there is some sort of stigma attached to Sign Language in the home. [...] The rejection of Sign Language by students in the classroom is a difficult issue for Orla. It is a source of shame for her and she says that makes her feel like a fool. Furthermore, the teacher who worked in the unit for the deaf said before that deaf people have bad English because they use Sign Language. (Professional 06, SNA, interview notes).

It is of course possible that these children prefer to use speech over Sign Language, though in comparing interviews with Orla above with the parents of those children and their teacher in the unit, several of them struggle with spoken language acquisition. Their rejection must be seen in the context of the negative discourse of Sign Language at play at home and at school. At home, Sign Language is constructed as a barrier to speech:

Niall can't sign at all, he's kind of learning, but not really. The mother doesn't really want him to learn yet. She thinks 'Oh the doctor said 'no, don't get him to learn yet, it'll stop his speech and it might make him over reliant on the sign' (Professional 13, unit teacher).

At school, their teacher (hearing, non-signing) blames the use of Sign Language for poor English grammar in one of Niall's classmates:

But the hardest thing was the grammar, trying to get the grammar proper, the sentence structure [in my student's] speech and his written work. He just doesn't have it, it's a link missing there, you know. I know it's because of the signs as well, because he would have probably signed first, you know, and you know that in Sign Language you don't have, like, the verbs, or you don't have "you go *to* the shop", it would be like "going shop", and that's what he writes down, and I found that the most frustrating thing for me, I felt I have to fix this but I can't, you know, sometime it just comes naturally, you know? (Professional 11, unit teacher).

While it is true that in the grammar of ISL the pronoun 'to' would not be used in the above sentence, it is an inaccurate conclusion to directly correlate poor English-language grammar with the use of ISL. English is being taught as a second language to this child, and if the rules of that language were explained through Sign Language (assuming that the child has an adequate grasp of Sign Language), such as the differentiated use of pronouns in each language, it is likely that they would improve. It is certainly not the case, as claimed by the teacher that "deaf people have bad English because they use sign language" (field notes).

Therefore, while Niall attends the unit and has access to Sign Language, a Deaf adult role model and D/HH peers, he is placed in an environment saturated with a negative discourse of deafness. When Niall was given an alternative to a medical model of deafness, he rejected it and is reported by staff to be embarrassed by the presence of the SNA. Coming from a home where his mother disapproves of Sign Language, and placed in a unit with a teacher who cannot sign and who believes that Sign Language is the cause of poor grammar in D/HH people, the presence of a Deaf adult within the classroom is not enough to counteract the processes of subjectification taking place. Niall does not believe that he is deaf, views no benefit

in Sign Language and does not want to be associated with anything highlighting his deafness. His teacher summarised the situation stating:

Do you know what's funny, I don't think they [the D/HH children] know themselves that they're deaf. ... Because I'd be saying 'Why do you have your hearing aid in?' Especially with Niall, now you know I'd be saying something like 'but you're deaf'. I wouldn't say it in a cruel way, but 'you don't have perfect hearing, you know, that's why you wear your hearing aid'. Niall would look at me like I've two heads! As if he doesn't nearly know himself. I thought it was very strange. They themselves are obviously not part of Deaf Culture because their families aren't part of it (Professional 11, unit teacher).

In spite of the fact that these children are educated in an environment with D/HH peers and a Deaf SNA, their teacher has concluded that they do not identify in any way as D/HH. This would signify the completion of subjectification, whereby Niall has externalised a hearing 'other' and eliminated the D/HH 'self' to such a degree that he does not identify himself with other D/HH people. Their teacher makes an important observation, that the fact that these children are from hearing families has in some way stopped them from becoming part of Deaf Culture. This is in spite of the fact that they have access to D/HH peers, similar to those in schools for D/HH children.

However, unlike children in the past who also came from hearing families, these children do not have the extended network of Deaf Culture that comes with specialised schooling. Similarly, their parents do not meet each other even though the children are enrolled in the same school, because of the long distances involved and the fact that their children are transported to and from the school by a funded taxi service. As a result, the geography of deaf education is changing significantly with the increase in mainstreaming, which is in turn impacting on the social and cultural spaces within which these children circulate. Significantly, this is having an impact on the geographies of resistance against the medical model, a topic which will be examined in the next chapter.

Conclusion

The reproduction of a hegemonic medical model of deafness involves a trio of individuals – ‘expert’, parent/teacher, and child. Section one dealt with the role of ‘experts’ in establishing speech as the preferred option through the use of authority, inducement and coercion of parents, and manipulation of information. Section two dealt with the role of parents/teachers as they carry the goals of the clinic into home and school. Section three examines the subsequent impact on D/HH children as they enter a process of subjectification, and eventually leads to the reproduction of the medical model through their own internalised rejection of social model alternatives.

Each individual takes a particular role in this process, and each aspect is spatially and temporally specific. The role of ‘experts’ is significant during early intervention in establishing speech as the preferred method of communication. Their ability to pool resources such as their clinical training, funding, service provision, and bureaucratic recognition as ‘expert’ gives rise to authority and manipulation of information through gate keeping as modes of power. The effect is parental subjectification, pursuit of speech and avoidance of Sign Language.

However, when the reality of the resources (both personal and financial) needed to teach speech, as well as the frustration of having a young child with whom you cannot communicate become apparent, a variety of other modes are implemented. Inducement and coercion create a negative discourse surrounding the use of Sign Language and either implicit or explicit disapproval from medical professionals maintain the dominance of speech, and transfer this practice to the family home where parents and their children are not monitored by professionals. As a result, the resources needed to achieve the desired effect (speech over Sign Language) are located at a distance from the effect itself as parents are subjectified, carrying the goal of institutions into the family home.

Parents (and later teachers) take up the task of speech instruction in the home and school. Monitoring use of audiological equipment and practising speech and language therapy become a significant part of the daily routine for parents and teachers. As such, home and school environments in turn become medicalised, extending the ‘power’ of medical professionals by allowing their resources to

achieve effects at a distance beyond the medical institution. Parents and teachers use resources available to them, in particular the ability to grant or deny desired objects to promote spoken language acquisition and discourage Sign Language use. For parents, this process is as a result of subjectification. In contrast, teachers are frequently caught in the case of top-down domination where they follow directions from 'experts'. While some teachers will disagree with this direction, in particular those with more experience with D/HH children, they are frequently bound by the authority given to medical opinion in the provision of resources in mainstream settings. Teachers working in full mainstream are less likely to question direction, perhaps on account of their lack of experience with D/HH children and instead simply follow it as it is given.

While experts, parents and teachers are all 'working on' D/HH children during early childhood, these children can and do challenge these relations as they mature and develop their own self-identity. Counteracting such challenges is addressed through the subjectification of D/HH children whereby they are called upon to self-discipline. This involves silencing alternative views of deafness, fostering a self-recognition of D/HH children through a hearing lens and continuing both of these processes through self-regulation. A combination of these forces means that even when children are provided with an alternative, they may reject it owing to their subjectification.

This reproduction of the hegemonic medical model of deafness means that there is little room for a social model in the current system of mainstreaming in Ireland. As illustrated by figure 7.5 below, the system instead sees a range of individuals (shaded blue) acting across different spaces (shaded pink) using various modes of power (*italics*) to 'act upon' the D/HH child.

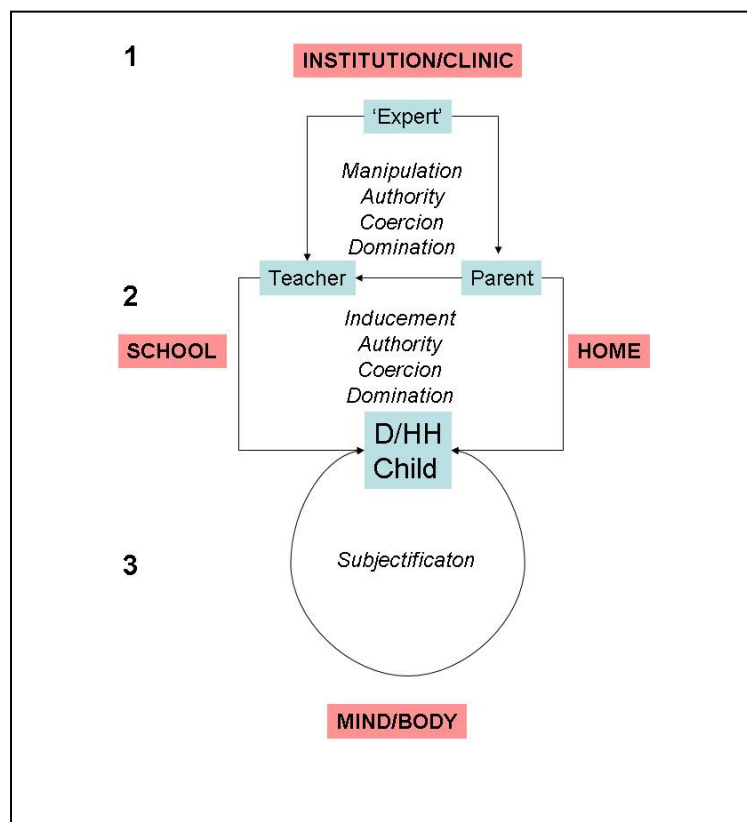


Figure 7.5 Three stages in reproducing a hegemonic medical model.

This runs against the philosophy of mainstreaming which holds ideals of inclusion and understanding at its core. On the contrary, mainstreaming is, in practice, an extension of institutionalised medicalization, though it takes this a step further than was the case in residential schools settings. This is because, in mainstream education, D/HH children have little to no access to their D/HH peers which previously provided opportunities for resistance (see next chapter). When they do have access to peers, the combination of power relations at play in clinics, home and school are frequently overwhelming to the point of disallowing successful resistance. As a result, mainstreaming brings the rehabilitation process into every aspect of the child's life through establishing speech as a goal, bringing medicalised practices to both home and school environments, and the subsequent subjectification of the D/HH child. It is this feature of mainstreaming that will be examined in the next chapter, in particular the consequences that the spatial dispersal of D/HH

children in mainstreaming has on the ability of that population to mobilise resources to allow them to resist this medicalization.

8 Collective Resistance and Dispersed Transgressions: Resisting a Hegemonic Medical Model of Deafness.

Introduction

The previous chapters have examined how a hegemonic medical model of deafness was established and is currently reproduced. However, since power is a relative concept, any act of domination can be met with an act of resistance. The focus of this chapter is on the changing geographies of resistance at play in the current system owing to mainstreaming and the subsequent impacts on the spatial organisation of D/HH children. This spatial reorganisation has an effect on the ability of the Deaf Community and their advocates to pool resources necessary to challenge a medical hegemony and threatens the traditional paths to resistance facilitated by the congregation of D/HH children in residential schools.

Chapter 4 dealt with the various theorisations of resistance. To summarise, resistance in this thesis is defined as an act, discursive or material, intended to strategically subvert or contest a dominant discourse. In particular, acts which promote a social model of Deafness in the midst of a dominant medical model are considered as acts of resistance. Acts that are unintentional, in this case often a pragmatic response to a difficult situation, but resistant in nature since they follow a social model of Deafness, are referred to as transgressions. These acts frequently lack the strategic intent to subvert a dominant discourse. The use of the term transgression/resistance is implemented to highlight the difficulty in distinguishing where one ends and the other begins, as well as the potential for acts of transgression to mature into acts of resistance over time. Similar to acts of dominating power, acts of resistance are myriad and varied. Since resistance is a form of power, the same arguments apply: resistance cannot be 'held', centralised, it is not a resource that can be drawn upon in its own right. Rather, it is a combination of resources and effects.

The forms of resistance to be examined in this chapter include non-consent, non-cooperation, disobedience, perseverance, mobilisation and protest⁴⁵.

This chapter focuses on the changing geographies of resistance, and the subsequent changes in the modes and degrees of success of the transgression/resistance tactics employed. As such, transgression/resistance as it was traditionally mobilised in the Deaf Community is examined first, in particular how this emerged from spatially concentrated sites of D/HH individuals and their resources. This discussion is followed by examples of contemporary transgression/resistance on the part of parents, teachers, the Deaf Community, and D/HH children. The chapter will conclude with a discussion on the limitations of contemporary resistance caused by the changing spatial organisation of deaf education. It is argued that the fracturing of these once central sites into a spatially dispersed system of educating D/HH children has threatened traditional forms of transgression/resistance and as a result, challenges to the hegemony of the medical model are less successful in the current system.

Traditional Resistance in the Deaf Community: Collective and Strategic Action

Throughout the history of deaf education, D/HH children have been clustered in residential schools. Upon graduation, these D/HH people frequently stayed in the urban areas in which they were educated giving rise to Deaf Communities. Collectively, they have pooled the resources available to them and they have employed a diverse set of tactics to produce resistant acts or effects. In line with identity oriented theories of resistance (see chapter 4), these acts were frequently along cultural or linguistic lines and involved the establishment of a Deaf identity, solidarity with the Deaf Community, and the defence of both. A number of specific examples follow, highlighting the diverse nature of these modes of resistance and the similarities between them. It should be noted that these examples focus on traditional forms of resistance within the Deaf Community that, by and large, arise out of collective action between large numbers of D/HH people, either as children

⁴⁵ There are other forms of resistance such as violence, conversion, accommodation, which will not be examined here.

in residential schools or as adults within Deaf Communities and advocacy societies. These examples are not exhaustive but rather exemplify the most typical strategies of resistance. Throughout this section, the term resistance will be used as opposed to transgression/resistance. This is because acts from within the Deaf Community against a medical model of deafness are strategic, and framed within the concept of a social model. The deliberate nature of these acts is what distinguishes them from transgression. The examples to be discussed below include self-definition as non-compliance, protest, and disobedience.

Self-definition as Non-compliance

One of the most significant manifestations of resistance is the non-compliance of D/HH people to subscribe to a medical model of deafness. This gives rise to self-definition as a form of resistance. This is the reverse of silence as a mode of domination described in the last chapter, whereby the social model of Deafness (manifested in Sign Language) was ignored and denied. Self-definition as a form of cultural resistance subverts the medical model by celebrating Deafness as a different, but valued way of life through both discursive and material practices.

A clear example the material nature of this resistance is the presence of Deaf Clubs worldwide, held together by national and international organising bodies and the overarching World Federation of the Deaf. These clubs facilitate the congregation of D/HH people and by doing so disseminate Deaf cultural traits and values. They also allow for the pooling of resources such as money, buildings, and human resource services. In Ireland, there is a plethora of Deaf organisations on national, regional and local levels. Irishdeaf.com has 60 listings for Deaf Clubs across Ireland (Northern Ireland included) and a further 56 Deaf Organisations. There are groups based on gender (Irish Deaf Women's Group), sporting interests (St. Vincent's Indoor Bowling Club), hobbies (Dublin Deaf Scouts), sexual orientation (Greenbow Deaf LGBT), degree and cause of hearing loss (Deaf Usher Syndrome support group), profession (Irish Deaf Photographers), and religion (Belfast Deaf Christian Fellowship). The existence of such a number of finely differentiated clubs exhibits the large and active community of D/HH people across

Ireland facilitating events specifically for D/HH people away from mainstream 'hearing' organisations. As such, D/HH people in Ireland widely participate in their own clubs, compete in their own Olympics (Deaflympics), and attend their own churches, theatres and summer camps. Many D/HH people also take part in mainstream activities with their hearing neighbours and friends, but the variety and number of Deaf clubs and organisations nationwide suggests a great need and desire for this cohort to socialise amongst their peers.

This congregation of D/HH people into their own clubs and organisations serves a purpose other than simple socialisation. Significantly, it fosters the transmission of information on the social model of Deafness and concepts of Deaf identity. It allows D/HH people to collectively challenge widely held assumptions about d/Deafness and create their own alternative narratives to these assumptions. As such, there is also a discursive side to these clubs. This can happen on an international scale. One parent who was herself Deaf commented on how her use of Sign Language with her children was influenced by her husband's exposure to international research at a Deaf conference:

When my children were growing up, my husband was [...] a board member of the Irish Deaf Society and he went to the World Federation of the Deaf and he saw a presentation on how important it was to continue signing to your children. [...] My husband kept saying to me "keep signing, keep signing, it's important". [...] I'm lucky and thankful that my husband had gone to the WFD, only for that I might have been confused, I might have been unsure of whether I should be signing or going for Oralism – I wouldn't have known where I stood (Parents 08).

The existence of Deaf clubs and organisations gives rise to self-identification and community building. While this takes place on a micro scale across the globe, with D/HH people running their own self-assertiveness courses and providing Deaf Awareness training locally, it has also had a macro level response, in particular through larger national organisations of D/HH people. This macro level collective cultural movement can be seen in the establishment of the Irish Deaf Society and subsequent forms of resistance, such as protest, which have been facilitated by that collective movement.

ISL Recognition and Protest as a Form of Resistance

The Irish Deaf Society (IDS) was established in 1981, the United Nations Year of People with Disabilities. It is a national level organisation for D/HH people run by D/HH people. It was the result of a growing collective movement of D/HH people in the greater Dublin area. Some years before the IDS was established, a small group of D/HH people began to organise weekly meetings called the Wednesday Group to discuss their dissatisfaction over service provision for D/HH. Initially, the main issues of concern were around interpreting services, securing a tax-free allowance, provision of psychiatric care, television subtitling, and establishing a telephone service for D/HH people. In 1981, on account of the fact that it was the European year for people with disabilities, the Wednesday group seized the opportunity to become a more organised network and changed their name to the Deaf Action Group.

Following its establishment, the Deaf Action Group held monthly meetings with large attendance primarily to mobilise the Deaf Community into self-representation in the matters that affected them and to have a general awareness of their rights. While it was only intended that the Deaf Action Group would continue its work for a year, when the year passed the demand for a permanent service was obvious. It changed its name to the Irish Council of the Deaf and later the Irish Deaf Society. Its visibility on an international scale developed with participation at World Federation of the Deaf meetings, and the IDS became a member of the Federation in 1985. A significant cause pursued by the IDS is the call for governmental recognition of Irish Sign Language, a call that frequently implements the use of protest.

Irish Sign Language has precarious legal status in the Republic of Ireland. While it is formally recognised in the Education Act (Government of Ireland, 1998), it is not officially recognised as a language of the state. The government officially recognises Irish (Gaeilge) and English as languages of the state. Leeson argues that since ISL is not recognised as a state language, the 'mother tongue' of D/HH children in Ireland is often assumed to be English/Irish, with ISL relegated to the status of educational tool (Leeson, L., 2007). Indeed, its formal recognition within the

Education Act would verify this assumption. Legal recognition of ISL as a state language would require constitutional change following a referendum. In spite of the fact that the issue has been raised in Dáil (parliament) on a number of occasions, the government response is that there are no plans to officially recognise ISL. The pursuit of legal recognition of ISL by the Deaf Community in Ireland is situated in a larger context of international movements and an increasing European policy giving protection to Sign Languages (Timmermans, N., 2003). Austria, Finland, Portugal, the Czech Republic, and the Slovak Republic have given constitutional recognition to sign languages in their countries (Leeson, L., 2007), and several others, including Ireland, have given some form of legal recognition (European Commission, 2010). This movement has grown to such an extent that Timmermans argues that "the question for governments is not anymore *whether* to recognise sign languages or not, but *when* and *how*" (2003: 3).

In response to this lack of constitutional recognition, the Irish Deaf Society has pooled a number of resources to campaign the government. In particular, it has enlisted the expertise of linguists and European policy documents pointing to the validity of Sign Language. To put its case on the national agenda, and to garner public support, the Irish Deaf Society has increasingly engaged in public demonstrations. In 2008, they launched Irish Sign Language awareness week⁴⁶. Over the duration of the week, events were held in seven locations across the country promoting awareness of Deaf Culture and ISL. The week's events culminated with the ISL pride march taking place through Dublin city centre.

The ISL pride march taking place during Sign Language awareness week exemplifies the use of protest as a means of resistance. Protest usually, though not always, involves a degree of organisation, and intends to strategically oppose a particular ideology. While it is not necessary, it often has a public component, and is ideologically informed. Marchers carried banners, placards and large foam hands and blew whistles to gain attention of passers-by. Starting at the Garden of

⁴⁶ This is recorded in the national media as the 'first' ISL awareness week. However, there was a week held in 2005 which also had a parade (personal communication, Irish Deaf Society), though it appears that there is little documentation about this particular event. As a result, this section will examine the events taking place in 2008.

Remembrance and concluding at St Stephen's Green, the ISL pride march made its way down the main thoroughfares of Dublin city centre: O'Connell Street, O'Connell Bridge, College Green, Nassau Street and St Stephen's Green. Significantly, this is a similar route to those taken by other civil rights marches in the capital, such as the annual Gay Pride Parade. As such, this particular form of protest aligns the Deaf Community agenda alongside that of other better-known minority groups and frames their movement within a broader human rights perspective. Following the parade, a large crowd gathered around the bandstand in St Stephen's Green to the presentations given by a number of Deaf Community leaders as well as performances by D/HH groups. As such, Deaf Culture as well as Sign Language became highly visible in a public space during a busy Saturday afternoon, garnering public support, raising awareness, and fostering a sense of community and pride among D/HH people.

The ability of parades to garner public attention makes them a popular tactic of resistance. Again, a combination of material and discursive practices are implemented with both the physical presence of D/HH people through the city, complemented by a clear rhetoric of Deaf-empowerment and the use of slogans in print, sign, and speech. Gathering a large number of D/HH people together, it creates a significant presence for Sign Language within an urban environment, a noticeable statement to the hearing community that the Deaf Community exists, is a large community, uses Sign Language, and is involved in advocating for its own rights. For the Irish Deaf Society, the ISL pride parade increased public visibility and media attention of the campaign. In the weeks up to and following Irish Sign Language awareness week, media coverage on issues relating to Sign Language and deafness increased dramatically, assisted by the fact that a well-known public presenter whose brother is Deaf joined the campaign and wrote articles for a number of national newspapers (Irish Deaf Society, 2008). While the parade has not achieved governmental recognition of ISL (yet), it has led to an annual pride march which is an important event in the Deaf Community social calendar. As such, the successes of the parade lie beyond quantifiable issues, and are more likely to be felt

in the impact that it has on the Deaf Community in its empowerment through self-advocating.

It is important to remember that the IDS itself is facilitated by the large number of D/HH people living in the greater Dublin area as a result of the residential schools for the deaf there. It is unlikely that any of this would have been possible if such centralised populations of D/HH people did not exist. Typically, strategic acts of resistance like the use of protest among the Deaf Community, have their origins in residential schools and the subsequent development of D/HH societies in close proximity to those areas. Indeed, the residential schools have themselves been a site of resistance for D/HH children, who through the use of disobedience subvert the medicalised system in which they are placed.

Disobedience and Sign Language in an Age of Oralism

Resistance among the Deaf community on linguistic grounds relies, of course, on the continued use and development of Sign Languages and extends, as described above, to campaigning for the national recognition of those languages. The use of Sign Language is the most common and most significant of these acts since it is in, and through the transmission of that language that Deaf Communities prosper and emerge. This seems to be, to some degree, an innate characteristic of D/HH people. It has been shown that even when D/HH children are completely deprived of access to Sign Language users, they have been shown to develop their own linguistically complex system of signs (Senghas, A. et al., 2004).

Collective resistance through Sign Language by pupils in residential schools has been an internationally uniform feature of oralist education. It would seem that in spite of adverse situations, ongoing surveillance, the threat of punishment, and the absence of D/HH adult role models, D/HH children will endeavour to communicate manually with each other at all costs. Indeed, the continued use of Sign Language among the Deaf Community globally throughout a period of extreme oralist policies signifies that resistance was successful, although the negative discourse surrounding Sign Language and the shame that students felt have had an impact on the perception of Sign Language, and those who use it within in the community.

Negative sanctions for using Sign Language were common when an oralist policy was implemented in the schools in Cabra during the 1950s. These sanctions continued for the following decades. Told that signing was a sin, D/HH children in these schools were made confess it to a priest and encouraged to give it up during Lent⁴⁷. They also faced physical sanctions as documented in the Ryan report on the commission into child abuse published in 2009, highlighting that physical punishment was common in the schools for the deaf in Dublin during this period, with some children stating that they were struck with keys or that they had their hands bound behind their backs to stop them from signing (Ryan, S., 2009). The constant negative stigma attached to signing was also a dissuading factor, with students believing that use of Sign Language indicated mental retardation and that speech was at all times the superior form of communication. McDonnell and Saunders (1993) highlight that this negative stigma extended beyond the school for students. Chapter 5 has already noted how parents were discouraged from learning Sign Language and how letters to future employers allowed effects of power to be achieved at a distance.

In spite of these sanctions, D/HH children during this period succeeded in secret and with great success to continue transmitting Sign Language from one generation to the next. In such an environment where Sign Language was forbidden, to sign was an act of disobedience, and to disobey was to resist. Grehan (2008) documents the various tactics used in transmitting Irish Sign Language amongst the different segregated groups within St. Mary's School for Deaf Girls. Students enrolled as day pupils at St Mary's travelled on a bus to school with pupils from St Joseph's (the school for deaf boys converted to Oralism later than St Mary's). They used this unsupervised time and contact with peers as a resource in resistance. On board the buses, they learned signs from each other, which they would in turn teach to the boarding pupils. The same was true of students who had D/HH parents, or

⁴⁷ Lent is a Catholic feast before Easter, celebrated for a period of approximately 40 days when people typically make a sacrifice of some kind. Children are frequently encouraged to give up eating sweet things for the period of Lent, for example.

older D/HH siblings. For those students without access to D/HH peers, they made up their own signs to complement those they remembered from their pre-oral days.

McDonnell and Saunders (1993) further note that in such a restrictive environment, every body posture and eye movement became recognisable among students as a sign. Linguistically, a number of strategically brief signs also emerged within ISL to denote that a teacher was approaching, indicating discursive changes to the language itself is a tactic of resistance. As well as transmitting Sign Language, students were also known to resist by helping each other in assessments and group auditory exercises, enabling their peers to meet their teacher's expectations (Grehan, C., 2008). Thus, Grehan concludes that

[t]here were clear differences in terms of what hearing teachers assumed deaf children could and should learn and what deaf children themselves knew they could do. In the gaps that arose, deaf children created strategies for coping with the stresses of oral education. These included in-cohort support strategies and on a more significant level, the development of in-cohort sign variants (2008: 27).

The agency of D/HH children during this period, in spite of the fact that they were isolated from their family support and in a very difficult educational environment exemplifies that peer contact facilitates resistance. Indeed, all of the examples of resistance mentioned in the sections above include a number of common characteristics.

Traditional resistance in the Deaf Community is collective, and frequently facilitated by the congregation of D/HH people in residential schools and their spatial concentration in neighbouring areas following graduation from those schools. This collectivity allows the pooling of resources, subsequent resistance and generating effects of power. Tactics of resistance were passed down from one generation of D/HH students to the next through the residential schools, thus giving rise to intergenerational resistance. Resistance is often for the protection of Sign Language.

On the other hand, we do not have the same examples of resistance historically on the part of hearing parents. This is most likely because, until very recently, D/HH children were educated in residential schools where they spent significant

periods of time away from their parents. Often, these parents were discouraged from learning how to sign, thus limiting communication within the home. In spite of this lack of parental resistance, the spatial congregation of D/HH children into their educational setting facilitated resistance from within the Deaf Community. This contrasts significantly to the current situation of deaf education where the spatial dispersal of students from each other prevents such forms of collective resistance. If resistance is to happen in the current system, it must come from a different source. Either parents must take the baton and begin to resist on their children's behalf or the intergenerational transfer of resistance tactics within the Deaf Community must be facilitated outside of the residential school system. The remainder of this chapter will examine both of these possibilities and examine the limitations associated with each.

Contemporary Resistance: Dispersed Transgressions

While strategic acts from the Deaf Community such as establishing Deaf Clubs, lobbying the government, and organising Sign Language pride marches can easily be recognised as resistance, the actions of parents is often framed, not as an ideological struggle but rather out of practical necessity within the home. As such, acts which are framed outside of the medical model and more often transgressions than resistance. They have nonetheless, the potential to develop into resistance.

These transgressive acts, such as using Sign Language or becoming involved with the Deaf Community, are frequently spatially and temporally limited, confined to early childhood before spoken language has developed and occurring only in the family home (before inducement and coercion come into play, as described in the chapter seven). For this reason, as a counteraction to the hegemonic medical model, their success is limited because they lack the intentional and collective action that would more likely cause an overhaul of the system. Nonetheless, these acts are of significance in that they affect the daily lives of parents with D/HH children as they try to negotiate the everyday implications of a hegemonic medical model, and in time they can develop into acts of resistance. Like resistance from the Deaf

Community, this transgression/resistance takes a variety of modes. The modes to be examined in this section include are non-compliance, perseverance and mobilisation.

Before discussing those acts, it is important to note that there were several other ways in which parents were assertive on behalf of their child. In particular, many parents engaged in letter writing, making phone calls, and lobbying their local TD⁴⁸ to secure services for their children. While these activities are resistant in their own right and indicate that parents are willing to fight on behalf of their children, they are not included in this discussion because they do not qualify as acts of transgression/resistance *against a medical model of deafness*. Frequently, fighting for these services meant fighting for medicalised interpretations of their children's condition: fighting for speech and language therapy, fighting for audiology, fighting for digital hearing aids. These facilities are basic essentials for many D/HH children, and the degree to which parents had to battle with service providers highlights serious difficulties with the system, as outlined in chapter 6. Instead, this section will focus on strategies that parents used to complement of social model of Deafness.

Parental Resistance

Non-compliance

When parents refused to think, act, or behave in a way that was dictated by a medical discourse of deafness, they were transgressing/resisting through non-compliance. This was frequently a pragmatic decision, cited on the grounds that following a speech-only route with their young deaf child simply was not practical, with frustration mentioned as the most common reason for opting for Sign Language. Parent 07 quoted below took Sign Language classes following the identification of her son's deafness:

We went to the Sign Language classes, just to have a means of communicating because obviously you couldn't go through life without being able to communicate. And if he wanted something out of the press [cupboard] I'd end up emptying the whole press to see what it was he wanted (Parent 07).

⁴⁸ Teachta Dála – an elected member of parliament in the Republic of Ireland.

This comment about emptying the whole press was repeated by another parent for whom the absence of a communication system meant that in order to establish what it was her child wanted to eat, she would take each item in turn from the press and show it to him until she found something he wanted. Several parents mentioned the practicality of Sign Language in these situations, in particular the need for an abstract communication system with their child that would enable them the flexibility of moving away from concrete objects, or emptying the press as it was. In these instances, parents did not conceal their use of Sign Language from medical professionals, although a few of them did speak of feeling guilty or concerned about the lack of approval they would meet. However, pragmatic transgression/resistance was often accepted by medical professionals, though it was seen as a short term measure until cochlear implantation or other services were in place, once again undermining the long-term role of Sign Language in the development of D/HH children. As such, when medical interventions took place, further strategies (outlined in chapter 7) were implemented to deter parents from Sign Language use.

In the case of the mother (07) quoted above who implemented Sign Language out of frustration, the cochlear implantation of her son saw a change from the medical professionals in their acceptance:

So then Michael, well once he got the implant they said 'that's it you're not allowed to sign any more'. And we were like 'what are we going to do, he can't, he doesn't understand this' (Parent 07).

This reaction from medical professionals involved using coercion and subjectification of parents to bring about a return to speech (see chapter 7). This reaction meant that while non-compliance was frequently employed by parents in their child's early intervention, it was viewed as a short-term measure and was not robust enough to withstand further domination tactics such as coercion from the medical profession. This is likely because the primary resource implemented in non-compliance is the right of the parents to make decisions regarding communication for their child. Once parents become convinced that the 'right' decision for their child is to concentrate on speech, this non-compliance frequently

ceases. For many parents, this was the only form of transgression/resistance evident, and they embarked on a speech-only route following that. A small number of parents persevered with their use of Sign Language. As a result, perseverance is examined in the next section of the form of transgression/resistance.

Perseverance

Parental choice to persevere with Sign Language is in spite of advice to the contrary from medical professionals was less common among the research group, but tended to emerge as a characteristic with those who had contact with the Deaf Community and saw their child as part of that community, thus subscribing to a social discourse of Deafness. As such, their decision became ideologically informed and was backed by the support of the Deaf Community. As a result, it employed more resources than simply parental rights and became more closely aligned with resistance considering the ideological aspects. When speaking with one parent about her decision to persevere with Sign Language in spite of being accepted onto the cochlear implant programme I asked:

EM: Have you had any sort of conflict with, with going to Beaumont, I'm not saying conflict in the, sort of you know, them fighting with you sense of the word...

Mother: (anticipates question) not to use Sign Language?

EM: yeah, have..?

Mother: (interrupts) no.

EM: have they been supportive of it?

Mother: (speaking assertively) I put my point across; 'I use the baby sign with her and that's it'.

EM: mmm.

Mother: (continuing in an assertive manner) I say it and I sign it, but I mean the way it was with Elaine we'd no way – we'd *no* communication [...] with her at all, and people just accepted that that's the way...

EM: so they [the cochlear implant team] had no problem with it at all?

Mother: oh no problem with it whatsoever (Parent 05).

It is worth noting that Parent 05 quoted above anticipated my question, perhaps expecting that the issue of Sign Language and the cochlear implant unit would come up. Furthermore, when I ask if they have been supportive, she doesn't say that they have supported her but rather begins to stress to me in an assertive manner that Sign Language (although she calls it baby sign, they were availing of ISL classes) was

simply a necessity for them. This mother had previous contact with the Deaf Community. It is possible, therefore, that she arrived at the hospital, much as she did to my interview, in anticipation of the issues surrounding Sign Language. In other words, she was 'armed' not only with her right to make decisions regarding her child's communication, but could also draw on information received from the Deaf Community, and continuing support from that community through networks established. When she asserted her position, she met with no further tactical domination from the medical professionals.

While Parent 05 used Sign Language out of necessity, and was successful in her perseverance because of her contact with the Deaf Community, other parents were successful because they framed their child's Sign Language use as part of their cultural experience. Parent 10 quoted below saw her child as part of the Deaf Community, and insisted that he continue using Sign Language, in spite of his spoken language acquisition, because she saw it as being part of his future:

I want him to have Sign Language because I feel he's going to be a part of the Deaf Community in some way at some stage in his life, in some way. I just, I want him to have it (Parent 10).

As a result, Parent 10's decision to use Sign Language is no longer simply pragmatic, but rather ideologically informed and one that she feels is in the 'best interests' of her child. As a result, when faced with coercive and subjectifying modes of power from medical authorities, she is better equipped to withstand that pressure and continue using Sign Language. It is important to stress that this does not equate with a quantitative discussion of power-as-capacity, whereby the outcome of a particular scenario can be predicted by measuring who has 'more' power in store (Allen, J., 2003). It does argue, however, that parents who can draw on more resources are more likely to withstand acts of domination from professional sources, in spite of whether or not they appear more or less 'powerful' in the institutions with whom they interact.

For many parents, the realisation that there are advantages to using Sign Language came too late. This became apparent to a number of parents when the

issue of second level education came up. Jane's mother had sent her to a mainstream primary school, with no Sign Language instruction, on the recommendation of the visiting teacher that they use speech only. However, noticing that her options for second level would be limited, Jane started to learn Sign Language at 11 and was later placed at a facility for D/HH children in secondary school. Her mother said:

But I think in primary school they cope ok, secondary school is the huge problem. It would be lovely to send them to their local secondary school, but the same supports just aren't in place (Parent 12).

Like many of the parents in Gregory *et al's* (1995) UK study, a number of the parents in this research spoke of regret or anger at having not been given the support to develop Sign Language. In the case of these parents, taking part in the research became a form of resistance in itself and often manifested in mobilisation with other parents.

Mobilisation

Mobilisation here involves deliberate and strategic action of some parents to network with professionals and/or other parents in an attempt to change the current system or to record complaints with the system as they experienced it. Parents of older D/HH children in this research were more likely to recount events involving mobilisation with other parents. Several of them approached the research itself as a process of resistance, and frequently spoke of wanting to help other parents, to prevent the same happening in other families as had happened to them. They combined this with other mobilizing acts, such as informing other parents of the value of ISL or campaigning for access to and information about ISL, and improvements in educational provision.

One such example of mobilisation is the collective action among parents of D/HH children in a given region to open a unit in a mainstream school. The unit in Geashill National School in Co Offaly was opened in the 1980s and is one of the earliest units for D/HH children to be opened in a rural setting in Europe. It came

about as a result of collective action of parents in the area wanting a local alternative to attending a school for the deaf. Due to an outbreak of meningitis in Co Offaly, a significant number of D/HH children were growing up in the area (personal communication, parent of a D/HH child). Their parents formed the Midlands Association of Parents of the Deaf and through campaigning they secured the unit in Geashill National School. While this demonstrates the collective action of parents in a given area, the current situation is somewhat different. The example of Geashill National School was as a result of a high concentration of D/HH children as a result of meningitis. This is a unique situation. For parents of children in mainstream schools, such collective action is less common as a result of the low incidence of deafness. Nonetheless, parents of older D/HH children engaged in other forms of mobilisation.

It may have been as a result of their growing confidence as parents of a D/HH child as well as recognising difficulties their D/HH children were experiencing that brought these parents of older children to such clearly identifiable acts of resistance. Experience became a resource in its own right during this phase, with parents using their family's journey with a D/HH child as a means of counteracting dominance from medical and educational professionals. For example, one parent was able to withstand the advice of her visiting teacher against Sign Language due to her growing level of experience with her son (now a teenager) who still struggled with language, as well as increased interactions with the Deaf Community. Returning from a Deaf Community event she noticed:

I have spoken to [the visiting teacher] about this and she feels that I'm going down the wrong route by going down the Sign Language route. And I don't agree with her after what I've seen (Parent 06).

This is in stark contrast to many of the parents of younger children discussed above who, on the advice of medical and educational professionals, would often cease to use Sign Language without argument.

Another mother, whose daughter Hazel had not learned Sign Language and was subsequently struggling in secondary school spoke with great emotion of her

disappointment at the system and her desire to use the research process as a means of resistance:

Now, I have all Hazel's books kept, because I hoped and prayed one day this day would come, where somebody would come and ask me what happened. ... [Y]ou know... that was a huge mistake. She should have been helped, she should have had Sign Language right, all the time (Parent 17).

Hazel's mother was one of a number of parents with older children who were adamant and angry that they had been misled about the use of Sign Language:

We can't help thinking we've made all the wrong decisions. We should have left [him] as part of the Deaf world. He doesn't have any deaf friends and he has nobody he can communicate with who understands his plight ... who can empathise with him really... I mean he doesn't have that group, that's the worst (Parent 07)

It was damn hard work for her in school, really. It was really tiring with all the lip-reading. [If I had my chance again] I think I would have pushed more for her to have been taught more through sign, or maybe [have] a listening-aid⁴⁹ to do something about it, to sign (Parent 12).

Gregory et al's (1995) study also highlighted a great deal of resentment from those parents who had been badly informed in the 1970s regarding the benefits of British Sign Language. One father of a Deaf adult man said "[w]e ought to have been taught to sign and we ought to have been encouraged to sign from the word go" (Gregory, S. et al., 1995: 51). While it could be argued that advances in technology make comparisons between those raised in the 1970s and the children in more contemporary research unfair, it should be observed that two of the three parents quoted above have children with cochlear implants, suggesting that cochlear implantation does not negate parental regrets at not learning Sign Language as their children mature.

⁴⁹ A listening-aid is somewhat similar to a Special Needs Assistant, an individual assigned to the D/HH child to help them follow what is happening in the classroom. At present, it is not a sanctioned service and no child in this research had one. Nonetheless, the Special Needs Assistant frequently does much of the same work.

Transgression/Resistance at School

Aside from parents, teachers also play a significant part in the day-to-day life of D/HH children. As such, they also present an opportunity for transgression/resistance. It was argued in chapter 7 that the school is a significant component in the treatment of the child's deafness through the provision of a spoken language environment. However, it was apparent that a number of school settings were also sites of transgression/resistance whereby Sign Language was made accessible to D/HH children, even those who came from families where Sign Language was not approved of nor implemented. All of the schools observed to use Sign Language to some degree (although it was more often signed English than Irish Sign Language) were those that had units for D/HH children. While all of the units visited had some degree of Sign Language, two schools stood out owing to their particular efforts in providing Sign Language to the children. These schools will be examined here. To protect their anonymity and that of the staff within them, they will be referred to here as School A and School B.

There were a number of common characteristics between both schools. They each had a significant number of D/HH children enrolled. There was a number of full-time staff, either in teaching or special needs assistant (SNA) capacity with both D/HH and hearing staff. Significantly, each school had a teacher working within it who had a strong background in Sign Language, which was perhaps the unique characteristic among these units compared to others. In those two schools, as a result, there were a number of strategies to support Sign Language development among not only the D/HH children enrolled in the unit, but also their hearing peers in the mainstream school, indicating a concerted effort in inclusion. In each school, a Deaf SNA acted as an Irish Sign Language tutor in the school, in particular teaching Sign Language to those classes in the mainstream system that had a D/HH child integrated for a number of subjects. The unit teacher in School A observed:

[the Deaf SNA] is teaching sign language to all the mainstream children in the school, so all the mainstream children get say about 20 minutes sign language once a week (Professional 14, unit teacher).

In School B, a hearing teacher along with the Deaf SNA team-taught Sign Language to the mainstream class for 20 minutes every evening. This also provided an opportunity for the hearing teacher to improve her own Sign Language skills (she had only started signing when she was appointed to the position of unit teacher) with the Deaf SNA acting as a mentor in that regard. In both schools, as a result of the crucial role of D/HH staff, they were viewed as valued members of the teaching team. This is in contrast to a number of other units where the SNA-teacher relationship was problematic and indicates that the resistance taking place in these schools had an ideological foundation.

In both schools it became apparent that Sign Language was on an equal level with English for instruction. Indeed, in School B the unit teacher noted that it was indispensable. When she started in the position, she had no Sign Language and she notes retrospectively:

I remember the first year, because I had no sign it was extremely frustrating. Once [the SNA] came, it's fantastic because it means the students are able to access the curriculum then, you know because you're able to communicate. When I was here for the first two or three months, if I ever had to check a word I would have to put on the DVD dictionary, it was pure crazy. It was so time-consuming [...] I mean I don't know how people survive (laughs) without it. I don't see how you could at this level, you need sign, you really do (Professional 19, unit teacher)

Nonetheless, they were aware that the appreciation of Sign Language in their school was not felt in all schools. Professional 19, quoted above, continued:

Teacher: I don't know how you feel about that [using Sign Language]? Do you not think so?

EM: Oh definitely.

Teacher: Some people *don't* believe in it. (Professional 19, unit teacher).

The provision of Sign Language in each of these schools gave an opportunity to D/HH children to access and develop their skills in that language. This was done while simultaneously developing their spoken language skills. Provision of Sign Language was seen as a way of ensuring that these children could fully access the curriculum, develop relationships with their D/HH peers, and progress in their language acquisition, but was not done *in place of* fostering spoken language

development. Those working in the units were aware that there was controversy surrounding Sign Language use, yet they continued to implement it on the grounds that it was the most appropriate avenue for their students. A crucial characteristic in both units was the presence of the Deaf SNA. In each situation the SNA was an active member of the Deaf Community, culturally Deaf, and a fluent user of ISL. This is only one method by which members of the Deaf community engaged in resistance on behalf of D/HH children. Other examples are discussed below.

Transgression/Resistance of the Deaf Community

The first section of this chapter outlined traditional paths of resistance taken by the Deaf Community in fighting for the protection of their culture and language. The examples used were frequently to the benefit of a collective (adult) Deaf Community. However, the Deaf Community also resist on the part of D/HH children born to hearing families.

One such example is the representation of the Deaf Community on the Advisory Committee on the Education of the Deaf and Hard of Hearing (hereafter referred to as the advisory committee). The advisory committee was established in 2001 to assess the current situation of deaf education in Ireland, the first examination of deaf education since the 1972 report (Department of Education, 1972). At the time, the Deaf Community had been active in lobbying a review of the deaf education system (Leeson, L., 2007). Nonetheless, when the advisory committee was established, there was poor representation of D/HH individuals on the committee itself. The Minister for Education and Science had been responsible for appointing members of the committee. In spite of increased lobbying from the Deaf Community, no additional appointments were made for that cohort (Leeson, L., 2007). As a means of resisting this poor representation, the Irish Deaf Society ensured that other means were accessible, in particular via submissions to the report.

A significant part of the advisory committee process was to invite submissions from interested stakeholders. While an advertisement was placed in national newspapers, the Irish Deaf Society produced and disseminated a call for submissions in Irish Sign Language. The availability of this material in ISL ensured

that a larger number of D/HH people could access the invitation. It is likely that this had an impact on the overwhelming number of submissions received from the Deaf Community. Sixty-seven out of the total 173 submissions were made by D/HH adults. This was double the next largest group of contributions, which was made by schools. It was hoped that this high number of submissions would have some impact on the outcomes of the committee, highlighting the negative experiences in education among members of the Deaf Community and the necessity of ISL in the school system. Unfortunately, in 2004 the advisory committee was disbanded before the report had been produced. In 2006, the National Council for Special Education (NCSE) sent out a call for a tender to edit and compile the material gathered by the advisory committee into the final report. This was completed by the Centre for Deaf Studies in Trinity College Dublin and submitted to the NCSE in 2007. However, to date the NCSE has not published that report.

In spite of the lack of movement from the government following the work of the advisory committee, the Deaf Community gathered some momentum in campaigning for improved education for D/HH children. In 2003, they organised a conference entitled "Are We Being Listened to?" which brought together parents of D/HH children, members of the Deaf Community, government representatives and educational experts. The 2005 conference once again revisited the issue of education. Putting the issue of deaf education on the agenda, the work of the advisory committee was not in vain and in 2006 a task force on deaf education was established, later becoming the Educational Partnership Group (EPG). The EPG has in turn produced a policy document, organised a number of conferences, and is in negotiation with the government regarding the establishment of a centre for educational excellence on the grounds of the residential school in Cabra. While it is clear that parents, teachers and members of the Deaf Community all engaged to some degree in transgressing/resisting on behalf of D/HH children, there are also some examples that these children act on their own agency.

Children Transgressing/Resisting

In spite of their educational isolation from D/HH peers, there were a number of examples of children transgressing/resisting the intentions of 'experts' and parents/teachers in this research. Two parents spoke of their children's continued use of Sign Language or gesture in spite of the family following an oral policy. Importantly, both instances were in families with two D/HH siblings, suggesting that collective action is still at the heart of successful resistance.

Chris and Ellen were both born with moderate deafness which deteriorated rapidly during early childhood. Chris uses digital hearing aids while Ellen has a cochlear implant. Their family is on a 'speech only' route. When I inquired about communication between them, their mother told me that they try to stress to Chris the importance of using speech with Ellen since she had received a cochlear implant - an example used in chapter 7. Nonetheless, Chris and Ellen's communication still involved a large degree of pantomime and gesture, as reported by their mother and observed during fieldwork in their home. During my interview with Chris and Ellen, they carried out a detailed conversation about the cochlear implant process using gestures to indicate going under general anaesthetic, the surgical procedure, waking up, and the after-care. Indeed, while their mother spoke to me during an interview about their choice for speech within the home, Ellen and her father held their own conversation beside us at the kitchen table. Her father had asked if she would like an orange, lifting and showing the orange to Ellen with raised eyebrows - indicating a question. Ellen nodded in reply. He asked if she would like the orange peeled. She responded with a questioning look to indicate that she had not understood. He used a gesture showing peeling the orange. She shook her head, held her left palm out flat and using a swift downward motion with her right hand landing perpendicular on her left, said the word "shop", meaning chop.

Gesture was indispensable in their home. While the importance of spoken communication was stressed to the children on a daily basis, through the continuous use of hearing aid/cochlear implant, repetitive speech and language therapy within the home, and direct commands from their parents that they should speak, the children fell back on gesture frequently, in particular when communicating with

each other. Unfortunately, since they lacked the linguistic structure of Sign Language, such gesture and pantomime could not be used for a complex array of conversations. Furthermore, in spite of the children's use of gesture, their parents could, when desired, eliminate their own use of gesture forcing their children to communicate through listening. In the second family with D/HH siblings, the presence of Sign Language added another layer to this resistance.

Grace and Joseph both attended a mainstream school with a unit for D/HH children attached. While their mother did not sign, they had access to a basic level of Sign Language within the school. The teacher used a combination of signs and speech in the unit, and their communication with the D/HH children in attendance was dominated by Sign Language. As a result, Grace and Joseph use a combination of Sign Language and speech to communicate with each other in the home. This created difficulties for their mother:

EM: do they use sign when they talk to each other, Grace and Joseph, do they use sign language with each other?

Mother: both, both, yeah.

EM: they use both?

Mother: they talk and they use sign. Sometimes if they don't want me to [understand]... (laughs)

EM: yes, I was wondering about that, how would that work? (Laughs)

Mother: and I say "what are you guys talking about?" And they are laughing (laughs) (Parent 15).

For Grace and Joseph, Sign Language can be used to communicate exclusively with each other, to the detriment of their mother. It also provides avenues for communicating with D/HH peers within the unit. Similar to the examples of parents in this section above, Chris and Ellen, and Grace and Joseph implemented transgressing strategies for pragmatic purposes, often in spite of the oral environment within which they are placed. The main resource implemented is the presence of another D/HH person in the vicinity, as well as the tendency to visual communication inherent many D/HH people even in the absence of Signed language. Communication difficulties are common between D/HH children and the hearing people in their midst, but between two D/HH children they can be insurmountable. Establishing meaningful communication with their D/HH siblings

often meant that these children transgressed/resisted the direction of those around them.

Limitations to Resistance

In spite of the variety of acts of transgression/resistance evident, there were significant limitations noticeable. Limitations occurred both in the individual acts of transgression/resistance across groups, as well as the inability of groups to resist collectively.

Acts of individual transgression/resistance among parents are often both spatially and temporally limited. They are spatially limited on two levels, taking place only in the family home and with individual family spatially isolated from other families. As such, while many families transgressed/resisted in this way, they lacked the collective action that could be made possible were they in closer proximity to each other. Temporal limitation is also on two grounds. These acts frequently only take place during early childhood. Furthermore, they frequently only lasted for one generation with resistance on behalf of their child ending once that child reached adulthood. It does not, therefore, have the intergenerational component that was characteristic of resistance from the Deaf Community. For example, the collective action of the Midlands Association of Parents of the Deaf in establishing the unit in Geashill National School came under threat once their children had left the school. Without a second generation of D/HH children coming up to replace the generation for whom the unit was established, the progress made in this area is diminished. This is a common characteristic among units for the deaf across the country, where numbers can go up and down dramatically over periods of time. A number of parents noted that there had been a unit in their particular area at one time, but that it had closed due to declining numbers. In order for parents to re-establish the unit, new forces of mobilisation must be established, leaving each generation of resistance to start, as it were, from scratch.

Another noticeable limitation to parental transgression/resistance was that none of the parents directly challenged the medical and educational professionals whose advice they felt had been biased and inappropriate, signalling again perhaps

the power embedded within the social authority of the medical model. The fact that these parents did not directly confront the system may be because they are still within medical and educational services, and may be uncertain about challenging the system upon which they are so reliant, considering the power of professionals to grant or deny easy access to services. While parents were inclined to fight for services that were endorsed by medical professionals (campaigning for improved SLT for example), they rarely engaged in debates around access to Sign Language, or the inaccurate advice that had been given to them. Those parents who spoke openly of going against the recommendations of medical staff were also likely to speak of uncertainty, worry, and guilt around their actions because they were not supported by the 'expertise' of professionals. At times, these expressions of anxiety were aired after the interview was completed, with these parents in some way seeking my 'professional' approval for their choices. The same parents were also prone to qualifying their criticism with statements of gratitude for the service, however poor, that they received from the doctors and teachers in their midst.

Therefore, while parents used transgression/resistance to implement Sign Language within their own homes, and often extend this to networking with other parents, there was little in the way of systematic challenge from the parents interviewed. The overall feeling was one of trying to achieve a balance of not confronting the system so directly that it would jeopardise their child's access to services. For some parents, this was a daunting and worrying task. Hazel's mother said:

It's very difficult to confront a system when you are not professional and nobody, you don't really, you don't really have, it was like, it was like being out in the ocean, and.. And it was like there was nothing there around to help except you were in a small wee liferaft, and I found it incredibly difficult, and I remember going home, I remember going home different days from school and I was very, you know I was very upset by all of the things that we had experienced in school. And, I remember praying continuously for about two weeks that God would give me guidance on how to speak to the teachers in a way that it wouldn't offend them but that it would get the best outcome for Hazel (Parent 17)

Another significant barrier to resistance is that there are parents who simply do not want their child to sign. For D/HH children embedded within a medical

model, speech is a symbol of success and overcoming personal physical obstacles. It is the product of successful medical intervention as well as intensive efforts on the part of parents. The implication is that if parents put the required time, effort and resources into teaching speech, they will see the benefits. Lack of progress can be offset by examples of other children who 'did it', and that if you just 'keep trying', 'the speech will come'. Resorting to Sign Language, conversely, is seen as a degree of failure, in particular since it is framed so negatively amongst professionals. Sign Language is something to be implemented if the child fails to acquire speech, or an appropriate option for children who have reached such an age where Sign Language will not impede their spoken language development:

[i]f he wants to learn sign language when he 16 or 17 that's fine. But at the moment we're just pushing on with vocabulary (Parent 02).

This brings to mind, again, the issue of subjectification of parents (see chapter 7) whereby they internalise the medical goal of speech and strive towards that at all costs. For many of these parents, Sign Language is an indicator of failure, and one they are not willing to accept.

Transgression/resistance among teachers and D/HH children is also restricted in that it largely relies on the ability to access Sign Language. The examples of School A and School B illustrate that resistance can happen, but that it is often in situations where at least one staff member has a background in Sign Language. The unit in and of itself is not the source of resistance. It is rather a factor of background experience (which gives rise to resources) among staff. For children, access to D/HH peers often in the form of a sibling, seems to be a key component in facilitating transgression/resistance. The examples given above are not typical of D/HH children the majority of whom are raised in hearing families and go to mainstream schools without access to D/HH peers. As such, this form of transgression/resistance is limited to those children who have access to those peers.

While resistance from the Deaf Community has increased in momentum in recent years, and is more structured given the facilitation of the Irish Deaf Society, it operates on a systematic level targeting government officials and frequently fails to

trickle down to parents, teachers and children. Typically, this form of top-down resistance has been slow to materialise as indicated by the absence of progress made since the establishment of the advisory committee on 2001, and indeed the general lack of policy change since the 1970s. Generations of D/HH children have come and gone amidst attempts at resistance from the Deaf Community with little tangible change to the system. In 2003 they asked "are we being listened to?" at the Irish Deaf Society conference, but the answer would appear to be a resounding no. Aggravating this is the fact that there is little direct contact between members of the Deaf Community and D/HH children and their hearing parents, contact that could give rise to collective resistance.

There are a number of barriers to contact between the Deaf Community and hearing parents. Primarily, hearing parents are not referred to services organised by the Deaf Community. Where they do access such advocacy services, they tend to be the services of Deafhear.ie, a national advocacy service run by hearing people for D/HH people. Contact between hearing parents and a Deaf-run advocacy service such as the Irish Deaf Society, on the other hand, is less common. The Irish Deaf Society is largely reliant on reaching parents through word-of-mouth. However, even when contact between members of the Deaf Community and hearing parents come about, a second obstacle is identified.

A number of parents interviewed for this research recounted their experience of entering the Deaf Community, an experience which they found to be unproductive and negative. Owing to the strong stand that the Deaf Community takes on the medicalization of D/HH children, they are vocal in opposition to cochlear implantation and the pursuit of speech. This is greatly at odds with the goals of hearing parents. One parent reported being told by a Deaf person working as an ISL home tutor that cochlear implantation was a form of child abuse. Another mother and father who attended private Sign Language classes spoke of their tutor's single-minded opinions on Sign Language:

Mother: [The class] is taught by a woman who is from the Deaf Community, and she actually doesn't believe in teaching [D/HH] people to speak...

Father: She only believes in the Sign Language. And through that connection I found my way into the Deaf Community and went to some of their meetings, which were very

harrowing. They were disastrous. I mean that was really, really upsetting, because they were a very closed community, they wanted people to stay deaf if they were deaf, they didn't agree with cochlear implants, or speech, or all that kind of therapy, or why did they have this endless testing of them, they know they're deaf - if they're deaf let them be deaf. And enjoy the silent world (Parents 21).

Another mother made her decision to send her child to the mainstream school because of negative experiences with the Deaf Community locally:

I wasn't just 100% happy with [the schools of the deaf]. It was bringing him into the Deaf world where we weren't made that welcome. We had kind of a few issues with that ourselves because we don't have Sign Language and any things that we went to, naturally enough we were strangers and we didn't feel very welcome...we tried that for quite a while and it just, I said to my husband in the end I said 'I can't take this'...I just felt it was too small a world for him, and we couldn't be part of it in any way, shape or form (Parent 20).

Even professionals working within the Deaf Community who would be familiar with the various debates in the history of oppression experienced by the Deaf Community regarding Sign Language spoke of the 'militant' nature of some members and the need for the community as a whole to make accommodations for hearing parents and the desire for speech. While the Deaf Community has a clear agenda regarding the need for a social model of Deafness, and recognition of the Deaf Community as a cultural and linguistic minority group, it appears that their strong opposition to the medicalization of D/HH children ultimately acts as a barrier to collective resistance between them and hearing parents. As a result, the two significant players who could collectively resist the system as it stands are not working together as successfully as they could.

This is not to say that all interactions between hearing parents and the Deaf Community are negative. A significant number of parents also spoke of positive engagement with the local Deaf Community, in particular the benefits that it brought to their children. Among such examples was attendance at summer camps organised by Deaf advocacy groups where D/HH children from a given region could meet each other, as well as meeting other D/HH adults. A number of parents also mentioned the ISL tutor as a positive role model for their D/HH child and someone with whom the child enjoyed communicating. However, at the national level a

significant effort would need to be made by those campaigning for the rights of the Deaf Community to reach out to hearing parents in a way that is sensitive to their hearing culture, and their desires for their child to have access to both hearing *and* Deaf communities.

Overall, while there were acts of transgression/resistance from a number of parties, these acts were often spatially and temporally constrained, limited to small numbers of children, and lacked a collective and intentional challenge to the system. The most significant transgression/resistance lies in the hands of parents who have the ability to make decisions for their children regarding language and educational placements. However, where parents feel they have been let down by the system, and there is the possibility for their actions to develop into resistance through intentionality, they are reluctant to bite the hand that feeds them, implying a fear of negative repercussions from service providers. Thus, the ability of professionals to monitor service access continues to be a significant resource available to the medical model. Parents rely a great deal on the scant services given by medical and educational professionals, and the authority (actual or perceived) held within those services, either through their ability to provide or deny speedy services, acts as a great deterrent to parents to challenge the system within which they are embedded.

Conclusion: Changing Geographies of Resistance

Acts of domination and resistance between social and medical discourses of d/Deafness have flowed over and back since the beginning of systematic education for D/HH children. Chapter 5 outlined how the domination of Sign Language in the middle of the 18th century gave way to oralism and a medical model of deafness in the early 19th century. The domination of the medical model strengthened through the 19th century culminating in the eugenics policies of the early 20th-century which sought to (violently) eradicate deafness altogether. The pendulum swung back towards the social model, however, towards the end of the 20th-century with the revival in Sign Language usage in the 1970s and 80s. This revival did not reach Ireland to the same extent that it was felt in the US, UK and Scandinavia for example. This is perhaps because oralism had a late arrival in Ireland, coming some

70 years after it did elsewhere. Those who oversaw the change to oralism in the 1950s were still stakeholders in deaf education when the Sign Language revival began, thus ensuring the continuation of a dominant medical model during that period when the social model was making ground abroad.

The late 20th-century revival in Sign Language was quickly followed with advances in audiological technology along with educational policy focusing on inclusion, the combination of which gave rise to large-scale mainstreaming of D/HH children, and a return to the domination of a medical discourse of deafness. Owing to the late revival in Sign Language in the Republic of Ireland, these technological advances and policy changes came too swiftly, before significant ground had been made in re-establishing ISL as a mode of instruction. One teacher summarised the system stating:

But then you see, well it was sign long ago, then in the forties it became oral, then we began to look in the eighties, we began to look at introducing some sign to back up the oral. ... The deaf then went very militant looking for their sign, and in a way they're right, and they weren't exposed to sign when they were in school and they felt very strongly that they missed out on education. And now, you've gone around now, you've gone to cochlear implant, so you're back again then to a huge oral emphasis again. So but like, the Department has never been part of that, all of these methods have changed and philosophies have changed, but the Department have never said 'Yes', they've always shied away from making a decision or taking a stand on it (Professional 14, unit teacher).

The absence of the Department of Education and Science in taking a stand, as that teacher put it, on the various methodologies means that medical professionals continue to dictate to a large degree what happens in schools. In particular, this latest swing back to medicalisation in the wake of cochlear implantation is different from those that came before it. This is because resistance to the medical model has traditionally been the realm of the Deaf Community, whose collective action has ensured the survival of Sign Language and the continuation of the socio-cultural model of Deafness. Residential schools, in spite of at times being a stronghold of medical discourses, were also responsible for congregating D/HH children in large numbers. From these congregations, Deaf Communities emerged fostering the growth of clubs, societies and organisations and subsequent collective action. It also allowed for the continued dissemination of Sign Language, in spite of oralist

philosophies. Because of this congregation, resistance to the medical model was intergenerational being passed from one generation of students to the next.

With mainstreaming however, this collective action of the Deaf Community is fractured. D/HH children are no longer congregated as they were during the residential school period. As a result, the collective action of the Deaf Community has lost the strength it once had in resisting medical models of deafness. This resistance is now largely in the hands of hearing parents. While other individuals can and do resist, parents continue to play the key role in decision-making regarding communication and educational placements. If these parents resist it is unigenerational, ending when each D/HH child enters adulthood since they are, in turn, likely to have hearing children. Thus, the intergenerational transfer of resistance skills from one cohort of D/HH children to the next is at risk because of mainstreaming.

Subsequently, mainstreaming as it is currently practised in Ireland remains heavily influenced by the medical model, a fact which Branson and Miller highlight for its failure:

The failure of mainstreaming for deaf people is seen to stem basically from the fact that they are mainstreamed in terms of a medical model of deafness. Despite the overt opposition to the use of clinically based assessments and, thus, to the use of medical models of "disability," even the most radical integrationists continue to define deafness as a pathology, as a lack rather than as a cultural difference based in a linguistic difference. Given the overriding ideals of the mainstreaming movement, the mainstreaming of deaf students is a blatant contradiction (2002: 219)

It is for this reason perhaps that there is such reluctance towards mainstreaming from the Deaf Community. As Baynton observed:

[t]he angriest objection to mainstreaming from deaf people is that in the name of liberating children from their supposed "isolation" in the deaf community, a true and potentially devastating isolation is risked. In the name of inclusion in 'the' community, deaf children are frequently denied true inclusion in any community. For the sake of an abstraction known as the 'mainstream,' deaf children are denied the solid and tangible fellowship, culture, language, and heritage of the deaf community (1996: 154)

No doubt, this is because mainstreaming, as opposed to presenting an opportunity for meaningful inclusion with hearing peers, is instead viewed as the final stage of

normalisation, begun in the 19th century with medicalization of deaf bodies, continued through the 20th century with pure oralism, and approaching completion in the 21st century through surgical intervention and complete assimilation with hearing peers. Indeed, it could be claimed that mainstreaming, instead of *deinstitutionalising* D/HH students, is merely *reinstitutionalising* them; rearranging their spatial organisation away from the brick and mortar institutes of segregated residential schooling into a spatially dispersed institution of local schools, while although they lack the spatial delimitations of traditional institutions nonetheless remain overtly driven by institutional ideologies and a medical model of deafness.

Thus, sentiments against mainstreaming are common from the Deaf Community with Ladd stating that "forceful clumsy attempts to mainstream not only deny the facts about being deaf but destroy much that deaf people and their friends have worked so hard to create, and may in the last resort to be seen as genocidal" (in Branson, J. and Miller, D., 2002: 219). This reluctance is also because of the negative discourses surrounding Deaf cultural traits that often circulate in the medicalised mainstream environment. In contradiction to the 'appropriate' environment of the mainstream classroom, schools and programmes for D/HH are juxtaposed as a 'threat' to the successful acquisition of speech.

As such, mainstreaming hits at the very source of where D/HH people have traditionally resisted the medicalization of their bodies: the residential schools. Mainstreaming has caused a great erosion of residential school options, and subsequently has closed off the potential for organised resistance among the next generation. This, along with the rapid increase in technological social networking (such as SMS, Facebook, MSN, and so forth) among the current generation of young D/HH people, means Deaf clubs are also under threat (Valentine, G. and Skelton, T., 2008). D/HH young people are much less likely to congregate now than in previous generations. As such, a strong history of resistance documented from the Deaf Community, a resistance which has provided much comfort to Deaf adults, is now under threat.

The uncertain future of resistance strategies, though it is rarely articulated as such, is likely to be the cause of much of the anxiety around the mainstreaming

process. In an effort to preserve their culture and advocate for the rights of D/HH children, the Deaf Community has, at times, come on too strong. Their passion, and at times militancy, can be understood and indeed commended but must also be recognised as a barrier to progress the point of view of hearing parents. Mainstreaming is, according to Crean (1997: 28), “destroying the embryo of the Deaf community”, but by concentrating on collaboration with hearing parents and by continuing the work of the Education Partnership Group, systematic changes could occur.

9 Conclusion

Power, Language and the Ideology of Mainstreaming Deaf Education

Social institutions, in this case education and medicine, are not neutral entities, but rather are often used as a tool for achieving specific political, social and economic goals (Green, A. et al., 2008). This is evidenced through the history of deaf education where, over the centuries, D/HH children have been at the mercy of changing social conditions and the ramifications they have on their education system. When systematic education for D/HH children began in France in the 18th century, soon traversing across Europe and North America, it held a religious goal: to 'open the minds' of deaf people to the teachings of the gospel (Baynton, D.C., 1996). Due to the central role of Sign Language in deaf education during this period, D/HH adults were valued members of staff (though still second to hearing teachers) as language role models for D/HH children.

This evolved in the late 19th century (later still in Ireland), as society was becoming increasingly secularised, and the primary goal of deaf education as a religious endeavour was no longer feasible. A change in methodology ensued, caused by a number of complex factors including the work of Dr. Jean-Marc Gaspard Itard in the National Institute for Deaf-Mutes in Paris in 1801 (Lane, H., 1976), a rise in the preoccupation with normalcy (Davis, L.J., 1997), and modernisation of the labour force and the subsequent demands for 'productive' workers (Baynton, D.C., 1996). Manualism (the use of Sign Language) soon gave way to an oralist methodology which aimed to integrate D/HH children, rehabilitating them through listening and speaking skills. The shift to oralism represented the establishment of a medical model of deafness, as D/HH children were classified, segregated and treated on the basis of their audiological deficiency. Hearing *loss* and the need to 'normalise' D/HH children became the prevailing discourse in deaf education at the time.

On an international scale, this shift was by no means peaceful, and turbulent battles ensued between the proponents of one side or the other (Winefield, R., 1987). While political debates raged between teachers, children gathering in residential

schools established their own form of resistance to the newly imposed medical model in their midst. In spite of the distinction between these oral and manual schools, and the fact that the oral method was almost exclusively used during this period, because D/HH children were still congregating they continued to sign, often developing new forms of Sign Language in the absence of D/HH adults (Saunders, H., 2004; Senghas, A. et al., 2004). Subsequently, residential schools, heedless of whether or not they were oralist in philosophy, provided a path of resistance to the Deaf Community and spaces where Deaf Culture and Sign Language were passed from one generation to the next.

This system of residential schools indirectly facilitating resistance from the Deaf Community continued internationally for most of the last century and has only been radically challenged in the last 30 years (15 years in Ireland due to later policy change). This recent change has been as a result of the rise in integration policies, pioneered by the United States Public Law I-94 and followed by similar moves across Europe. In Ireland, integration or ‘mainstreaming’ was only enacted in legislation in 1998 (*Education Act*) and more forcefully in 2004 with the *Education for Persons with Special Educational Needs Act*. While there were instances of children who were D/HH being educated in their local primary school before this, this legislative backing has seen unprecedented numbers of D/HH children moving into the mainstream.

In particular, there has been an increase in the number of profoundly deaf children who previously would have almost exclusively attended schools for the deaf. Along with the legislative moves mentioned above, improvements in hearing-aid technology, in particular the development of cochlear implants, has meant that this cohort is now viewed by some as being most appropriately educated in mainstream environments to enable them to benefit from immersion in a spoken language environment, surrounded by hearing peers. Subsequently, the spatial organisation of deaf education has changed radically in recent times and for the first time since systematic deaf education began, there is no longer extensive congregation in residential schools, and D/HH children are instead dispersed amongst their hearing peers. As a result, the geography of deaf education has

changed in the last number of decades, and this spatial dispersal of D/HH children brings with it new consequences.

Contribution of this Thesis

This thesis aimed to critically examine mainstreaming of deaf education in the Republic of Ireland and its effect on the Deaf Community, making empirical, theoretical and methodological contributions to the field.

Empirically, it has addressed the almost total absence of research on deaf education in the Republic of Ireland by creating a snapshot of the situation in the wake of mainstreaming. Research on deaf education in the Republic of Ireland was confined to a small number of works chronicling the history of deaf education. The contemporary situation had not received an extensive overview since the 1972 report (Department of Education, 1972). The findings presented in this thesis begin to address this lacuna by examining the policy of mainstreaming through legislation analysis and comparing this to practice as illustrated qualitatively through interviews with parents, D/HH children and professionals, and quantitatively through survey data from units within mainstream schools. The policy of mainstreaming was established by examining the *Education Act 1998*, the *Equal Status Act 2000*, the *Education for Persons with Special Educational Needs Act 2004*, the *Disability Act 2005* along with the relevant Department of Education and Science (DES) circulars to build a picture of the policy agenda. As such it achieves the objective of outlining how deaf education is organised in the mainstream and what services should be available in Ireland at present. It also positions the system in the Republic of Ireland within a wider framework of international practice.

As well as this addition to national literature on deaf education, it also broadens the scope on international literature in this field by framing the situation of deaf education in an explicitly theoretical way, exposing the ideologies of mainstreaming. While a great deal of literature exists on deaf education internationally, research in the field is overwhelmingly quantitative and empirical in nature. It rarely engages with the ideological and theoretical aspects of pedagogy and education. To counteract this, this thesis sought to examine the implications that

mainstreaming has for the tensions between medical and social models of d/Deafness which have traditionally shifted during periods of educational reform. McDonnell highlights that approaching such a study through the lens of ideology is particularly advantageous, not least because "[t]he way in which disability is defined ... will influence the kinds of solutions to problems that are proposed and how resources are allocated" (2007: 10). By focusing on the hegemony of the medical model, the ideology supporting the deaf education system is exposed, along with implications for service provision. Although the tensions between social and medical models have been well-documented in the Deaf Studies literature (for example see Baynton, D.C., 1996; Branson, J. and Miller, D., 2002), they tend to focus on the historical aspects of those arguments. While sensitive to the historical context of deaf education (see chapter 5), this thesis focuses on the contemporary system and how the mainstreaming agenda fits into larger debates on the classification, treatment, and normalization of D/HH children. The writings of Michel Foucault were particularly influential in this regard given his examination of institutions (1965), his history of health (1980) and medicine (1977a), and his pronounced interest in power and subjects (1982). Following from Foucault, it examined how a medical model of deafness was established historically, and is currently reproduced and resisted in the context of mainstreaming. In doing so, this thesis adds to our understanding of mainstreaming by explicitly exposing the power relations at play between models of d/Deafness.

As a result, these findings also contribute theoretically to literature on geographies of power. Chapter 7 explores how these power relations begin to surface after identification, when services provided to families of D/HH children are predominantly medical in nature and can be viewed as preparing the ground for mainstream schooling. The institutional nature of diagnosis (in that it is carried out in clinics) means that it is hearing, medical professionals, and not members of the Deaf Community, who steer the course of early intervention. Several modes of power, such as manipulation of information through gate-keeping and coercion of parents are implemented to establish speech as the preferred method of communication during this early period. It is at a particularly vulnerable time for

hearing parents when decisions regarding early intervention are made, a time when parents rely heavily on the advice of professionals in their midst, and lack contact with the Deaf Community and alternative perspectives on d/Deafness.

The continuation of the medical model of deafness following the early intervention period relies on the instigation of a negative discourse of d/Deafness, and in particular Sign Language. This becomes necessary because, in spite of the system within which they are embedded, many hearing parents of D/HH children in Ireland still choose to use Sign Language as a means of communicating with their child at some stage. This transgression/resistance initially indicates some hope that the future of deaf education in Ireland will be guided more by the social model of Deafness than it is at present. However, as was shown in chapter 8, the fact that this transgression/resistance is temporally restricted (often only taking place in early childhood) and spatially limited (confining itself to the family home) decreases the potential impact that this move could have on the overall system. This is aggravated by mainstreaming which limits interaction between D/HH peers as well as the interaction of their parents with other parents of D/HH children.

Thus, the nature of transgression/resistance from parents in introducing Sign Language to their children has a somewhat fractured result, preventing intentional collective action that might truly challenge the hegemonic medical model currently at play. Similarly, resistance from D/HH children and teachers is limited to a handful of situations where Sign Language is made readily available or where D/HH peers come together. While the Deaf Community resists collectively, they too have little access to D/HH children and face several barriers in infiltrating the education and medical systems. As such, while acts of transgression/resistance occur from numerous bodies, there is a lack of collective action giving rise to a systematic challenge.

With this focus on power, this thesis contributes to key debates in geography on issues of power and resistance. Examining power as dispersed or immanent, it also adds to work on Foucauldian geographies. It does so by providing a specific example on the spatial operations of power in a decentralised system. It strove to answer Allen's (2003) demand that we take the temporal and spatial constitution of

power (in its various modalities) seriously by explicitly examining the spatial nuances of power as it is played out in the mainstream system. This example is particularly relevant for this topic, since the spatial processes inherent to mainstreaming focus on decentralisation and the dismantling of previously visible institutions. As such, it provides a specific example of the constitution of power across dispersed spaces, or at a distance, an issue of concern to Allen (2003). Reflecting on Foucauldian analyses of power, Allen argues that

[o]nce the confined arrangement of the prison or the clinic or the military barracks gave way to the dispersed arrangements of government, there seemed to be less curiosity about how a diverse and scattered population could be drawn within reach (2003: 191).

To counteract this lack of curiosity in a de-institutionalised system, this thesis distinguishes between resources and effects of power in terms of spacing and timing to examine how power might operate once dispersed. With this in mind, the effects of power can be different both temporally and spatially from resources used to achieve them.

Contrary to Allen's (2003) claim that power does not move, the evidence from mainstreamed deaf education shows that the movement of power from institution to home/school can be clearly traced through the transfer of medical goals from expert to parent/teacher to child. It is the ability of resources and effects to operate at great distances from each other, involving numerous modes of power shifting in the relational encounters between individuals that allows for movement of power from institution to home and school. For example, parents may experience power as authority or domination when they are being advised within a clinical setting. However, how the effect is then achieved within the home can be somewhat different. It may then and there take the form of seduction or inducement, where parents continue with a particular practice (avoiding Sign Language for example) because they feel that it is 'best' path for their child. However, this decision cannot be read out of the context of the use of authority within institutional spaces as it is intrinsically linked to that practice. Parents, in turn, are then in a position to draw on resources available to them to obtain the desired effect from their child – to speak.

Within the family home, parents can use their authority, and ability to grant or deny desired objects to their child as a means of encouraging speech. As such, parent-child relations come to reinforce the desired goals of medical institutions, as parents (themselves involved in powerful encounters with medical practitioners) replicate these relations in the home with their child. As a result, while power is dispersed in the mainstream setting, the role of the institution is still a significant one in disseminating goals with the destination of power (effect) clearly traceable to its institutional source (resources).

Acknowledging that any form of domination can be met with resistance, the resources used and modes of power employed in maintaining a hegemonic medical discourse of deafness must be capable of adapting in the face of resistance. In the case of encounters between parents and professionals, this thesis highlighted that when parents resist (to whatever degree) the mode of power used by professionals is often amplified. For example, manipulation of information gives way to coercion. Similarly, parents who use a more forceful form of transgression/resistance (such as perseverance) are often more successful in warding off further acts of domination from professionals. This transformation has a distinctly temporal aspect, with parents more likely to engage in more forceful modes as their child grows older. This is also a product of resources, however, with those parents having access to the Deaf Community or those with greater levels of experience (perhaps as a result of having multiple D/HH children) being better equipped to employ multiple forms of resistance.

In summary, the mainstreaming process highlights that power is a complex, heterogeneous and context dependent force and that any seeming hegemony is unstable and comes with the possibility of resistance. Several modes are used to reproduce, maintain and resist against this hegemony. Manipulation and coercion of parents into using a speech-only approach is used to maintain a monopoly of power among hearing professionals - by prioritising speech, hearing and speaking professionals are desirable - by denying Sign Language, Sign Language users are undesirable. These modes of power are mobilised through a variety of resources, especially authority as manifested in government recognition as an 'expert' in the

field, the ability to identify hearing loss and steer early service provision, trust from parents, and the capacity to intervene in educational practice. Non-compliance, perseverance, mobilisation and protest are used to resist this hegemony, though this transgression/resistance is temporally and spatially restricted and rarely involves collective action.

As well as this theoretical contribution, the thesis adds to our understanding of methodological choices while working with communities of whom we are not a member. While it confirms the need for participatory research with minority groups, it extends this beyond participatory methodology to examine what a transformative emancipatory epistemology might mean for research design and implementation. It proposed a Freirean approach which challenges the researcher at all times to consider their position vis-à-vis the community with whom they are working and to approach research as a means of emancipating and transforming an oppressive situation. As such, it explicitly calls for an examination of the power dynamic between researchers and the community with whom they work. In the case of this thesis, this examination was public, with presentations given to the Deaf Community openly accepting my privileged position as a hearing researcher and my commitment to using that privilege as a means of empowering D/HH individuals.

As such, it acknowledges the difficulty in conducting transformative emancipatory work within the confines (both temporally and academically) of the PhD. It therefore views this doctoral research as one component of a longer term engagement with the Deaf Community, concurrently accepting the limitations of conducting research within postgraduate education while viewing the potential for opening up possibilities for extending research beyond this realm. It also questions the role of academic researchers and their ability to engage in long-term commitments with research communities. In an increasingly competitive academic environment which prioritises diverse research experience and prolific publication, what is the role of those working within a transformative emancipatory setting? Can researchers continue to work towards and maintain academic credibility while simultaneously following a Freirean approach; establishing meaningful relationships with a minority community (itself a time-consuming process); empowering those

communities through shared ownership of research projects (not only tokenistic); and demonstrating commitment to their cause?

In summary, this thesis has a number of significant findings empirically, theoretically and methodologically. Empirically, it addresses significant gaps in the national research by providing empirical material on mainstreaming of deaf education in the Republic of Ireland, while simultaneously expanding our international body of research on mainstreaming through an explicitly ideological study of the phenomenon. Methodologically it highlights the challenges of a transformative emancipatory epistemology but also the possibilities made available through a Freirean approach to this type of research activity. Conceptually, the most significant finding of this thesis is that, far from fostering tolerance and inclusion of diversity, the mainstream system is used as a space for normalising and medicalising D/HH children. While a great deal of anecdotal evidence existed among the Deaf Community, a lack of concrete findings presented difficulties in challenging the system. This thesis has shown that, in spite of public declarations otherwise, medical professionals are *still* directing parents against the use of Sign Language with their D/HH children. While it was suspected that the mainstream classroom was used as a strategy for fostering spoken language acquisition, no evidence existed to support this assumption. Again, this thesis has shown that even when the educational and social development of D/HH children is at stake, they are frequently kept in mainstream placements on the direction of medical professionals to provide immersion in a spoken language. This is contrary to international best practice and what we know about the necessity of early and fully accessible language exposure in the development of young children. The inclusion agenda is frequently framed as a positive step forward in embracing the social model of disability and creating greater equality between disabled and non-disabled students. In the case of D/HH students, however, mainstreaming is used to support an explicitly medical agenda, denying access to Sign Language and D/HH peers while ensuring a continuous immersion in spoken language. It is thus the antithesis of the social model, focusing instead on the pathological condition of the D/HH child and on treating the child to prepare him/her for assimilation in mainstream environment.

Thus, the Irish deaf education system in its present state is characterised by a robust hegemonic medical discourse. This is in spite of calls from the Deaf Community to be recognised as a cultural and linguistic minority group and to accept and promote the value of Sign Language in the social and academic development of D/HH children. The hegemonic medical model must be viewed within the context of a long history of the authority attributed to medical and educational professionals, which legitimises their goals, in spite of their limited personal experience of deafness, knowledge of Sign Language, or interaction with the Deaf Community. The result is a view of deafness as a deficient condition which can be remedied through the use of speech instruction and by avoiding the most obvious signifier of Deafness: Sign Language.

Dissemination

While the primary purpose of this research was for completion of a doctoral degree, the dissemination of research results back to the communities involved is an important part of the process, and indeed central to a transformative/emancipatory research design. Researchers have, in the past, neglected to disseminate their research in an accessible format to people with disabilities (see Kitchin, R., 2000 for discussion). This has been addressed in this project in a number of ways. Primarily, research has been disseminated via presentations both within and outside the academic arena. In particular, presentation at conferences relevant to the communities involved (the Irish Association of Teachers in Special Education) as well as specifically organised less formal events (through Deaf Clubs and centres) has allowed for results to be distributed.

A significant aspect of dissemination has been the ongoing collaboration with the Task Force on Deaf Education. This task force is comprised of representatives from the Catholic Institute for Deaf People, Deafhear, the Irish Deaf Society and the Centre for Deaf Studies. In 2010, they produced a policy document for submission to the Irish government outlining recommendations for the future of deaf education in Ireland. A summary of findings from this research was produced and added as an appendix to this document. I have also attended a number of the

Task Force meetings and have provided feedback on the various stages of their proposal. With this step, the pragmatic impact of the research has already been felt and may contribute to future policy development.

It is also intended that following the completion of the PhD, a summary of findings will be made available in ISL and stored in the library of the Irish Deaf Society. Provision of results in this format allows for a broader reach of dissemination and also ensures that an accessible version of the material will be available for future generations of D/HH researchers. Funding is currently being sought to make this project possible.

Parents and professionals will all be notified following the completion of the PhD via letter and given access to a summary of findings made available online. Many of these participants have already received a copy of findings in the form of the task force document mentioned above. Children will also receive a letter in plainly worded English highlighting the relevant findings for them.

Expectations, Limitations, and Implications for the Future

Over the course of the last five years, one of the recurring aspects of this research was that it was 'highly anticipated'. It has been almost four decades since there was a nationwide systematic examination of deaf education in this country. The Deaf Community, parents of D/HH children, and service providers all spoke of concern regarding the system at present. Unfortunately, this research could not address all of these concerns, nor meet the expectations of all of the individuals involved.

In spite of the difficulties presented, however, it strove to unpick the experience of mainstreaming for the participants involved. However, since this research was qualitative in nature, it does not attempt to represent the situation of *all* D/HH children in the Republic of Ireland. There will undoubtedly be many individuals whose stories do not resonate in the accounts presented in this thesis. While attempts were made to ensure that the participants represented a variety of geographical locations, educational settings, communication choices, and age groups, the research is nonetheless restricted by the small numbers involved. The absence of large-scale quantitative data on deaf education in Ireland further

aggravates this due to the inability to contextualise this qualitative data in a larger quantitative framework. As a result, this work has a number of implications in terms of future research.

Research Recommendations

A large-scale, quantitative, nationwide census of deaf education is needed to establish demographic information on educational placement, as well as educational, psychological and social measures. A regular case load survey is carried out by the visiting teacher service, but since access to this information is blocked, the content of this data is unknown. Should this information already be gathered by the visiting teacher service, it should be made freely accessible to researchers and other stakeholders alike.

Further research exploring D/HH children's accounts of their experience in mainstream must also be addressed. While a number of interviews were conducted with D/HH children and young people, these were significantly outweighed by interviews conducted with professionals and parents. As a result, the voices of these young people, while present, do not dominate the thesis. This is a product of the focus of this research on language choices in early childhood, a topic which is best examined by talking with parents. Nonetheless, the importance of documenting young D/HH people's experiences in mainstream schools is acknowledged and would be a valuable, if not imperative future study. An understanding of the processes involved around decisions made by parents in early childhood, as presented in this thesis, will be a significant contribution to a future study of that kind. As such, while it is regretted that D/HH children and young people did not make up a more significant part of the research participants in this study, the discussion in this thesis emerged organically as a necessary prelude to any further research involving this cohort.

As well as young D/HH in general, another cohort underrepresented is D/HH children of D/HH parents. This is a small but significant section of the population who have particular educational needs. Frequently, ISL will be the language of use in the home, and the first language of these children. As such, mainstreaming may

involve the provision of ISL interpreters to allow such children to access the curriculum. At present in Ireland, based on anecdotal evidence from the Deaf Community, the majority of these children attend residential schools for the deaf. This is likely to be not only as a result of language issues, but also because of the historical significance of these schools and the likelihood that their parents are past pupils themselves. Nonetheless, some D/HH parents would desire that their child attend the local mainstream school, but the extent to which that is a possibility for them is, at present, unknown.

The increase in D/HH children born outside of Ireland has also brought a new dimension to deaf education service provision. Many of these children will come from families where English is a second language, or may not be spoken within the home at all. As such, issues of language acquisition involve not only the acquisition of a first language (be that English and/or Sign Language), but also the language of the home. While several children within this cohort were involved in this research, the specific nuances of their situation were not examined in detail. A further study looking to the needs of this cohort would be recommended, especially considering that they make up a significant minority within the deaf education sector⁵⁰. The same could be said for D/HH children who have multiple disabilities. Their educational needs are particularly complex. Given the high numbers of D/HH children with multiple disabilities attending schools for the deaf, it would appear that mainstreaming is not deemed to be an option for those children.

Since all research is subject to the constant changing conditions of both policy and practice, this research must be contextualised through the sociopolitical and economic conditions within which it was gathered. In particular, the fieldwork stage of this research took place during the late phase of the 'boom' years, with some of the later interviews being conducted as the economic downturn began. As a result, the full impact of the economic recession in the Republic of Ireland is not

⁵⁰ There are significant numbers of D/HH children born outside of Ireland within the Deaf Community. This is likely to be as a result of higher levels of deafness in other countries, in particular where the rubella vaccine is not available. Higher levels of congenital deafness exist amongst such populations. Furthermore, having a D/HH child was also cited by some participants as a reason for moving to Ireland, where cochlear implantation is provided by the national health service.

represented in the accounts of this thesis (with the exception of one or two parents). Subsequent cuts to special education resources, in particular the scaling back of special needs assistants may indeed have changed the situation that many of the parents in this research are facing. The continued recruitment embargo in the Health Service Executive will also have an impact, in particular on audiology and speech and language therapy services which were both already under-resourced. Furthermore, personal financial situations due to loss of employment may see a decline in the number of parents securing private services. Further research following these cutbacks may be necessary to establish if additional difficulties have presented themselves.

In spite of the economic recession, there are a number of positive developments in the pipeline for deaf education in Ireland. Most significantly, the Catholic Institute for Deaf People is planning the development of a "Deaf Village" to be located in Cabra. This will concentrate service provision and see the establishment of a centre of excellence in deaf education. The impact of this development on mainstreaming of deaf education will also warrant examination. So too will the reaction of the Department of Education and Science to the policy document on deaf education. This policy document was compiled by the Catholic Institute for Deaf People, the Irish Deaf Society, the Centre for Deaf Studies (Trinity College Dublin), and Deafhear. This is the first time that these organisations have come together in such a way and marks a significant step forward in the community relations and cooperation between the various organisations involved in services for D/HH people. It might, therefore also open further opportunities for collective resistance.

Policy Recommendations

This research showed that lack of early identification and intervention programmes, difficulties in availing of fundamental services within mainstream classrooms, and the continued ambiguity about the role of Irish Sign Language in the education of D/HH children all combine to produce a confusing and difficult path for parents and their children. There is a grave need for policy change in this area and to situate the

Irish system within the context of international best practice. Until such time, the prospect of mainstreaming deaf education remains full of ambiguous potential, uncertainty, and insecurity. As a result, and in line with the obligation for concrete change as part of a transformative emancipatory framework, the following policy recommendations are made.

Universal Newborn Hearing Screening should be implemented and rolled out without further delay. The quality of service delivery, in particular occurrence of misdiagnoses should be monitored. The current economic downturn should not be a deterrent to the implementation as the scheme is cost effective within 4 years and shows savings thereafter (Deafhear.ie, 2008). Upon identification, parents should be presented with a nationally standardised information pack – also available online – detailing all of the services available to their child and contact details for those services. General information on language acquisition and cognitive development in D/HH children might also be included so that families can make an informed decision regarding communication. Similarly, an introductory pamphlet should be made available free of charge online to teachers with D/HH children in their classroom outlining issues of concern to deaf education, such as how to improve access to communication, services and resources available (along with contact details for such) and links to relevant organisations.

Early intervention in language acquisition should begin immediately and should follow a bilingual model, introducing the child to *both* speech and ISL in a consistent and equal manner. This intervention can be facilitated by the Visiting Teacher Service through audiology and speech and language therapy services, and the ISL home tuition scheme respectively. As part of this process, the advice that ISL is detrimental to intellectual, spoken language, or literacy development as is given at present by several professional sectors must be halted and examined as a matter of urgency. The possibility of an in-service course for those sectors on the role of ISL and bilingualism for D/HH children should be examined.

A review of audiology and speech and language therapy services nationwide is needed. This should most urgently be addressed in areas where posts have remained vacant for a number of years. This review should include, but not be

limited to, waiting periods for appointments and access to in-service training for staff. In the meantime, speech and language therapy should be made available in units across the country to cut down on travel time for parents and to maximise cost efficiency. The possibility of allowing D/HH children in full mainstream programmes where there is a Special Class for Children with Specific Speech and Language Disorders to have access to the speech and language therapist on the school grounds should be examined. This may need to happen outside of school hours so as to not diminish the contact hours being provided to those children already enrolled in the class.

In terms of education policy, continuity of choice must be fostered by actively promoting the units and schools for D/HH children as viable options for those children where mainstreaming is not a feasible option. Units and Schools for D/HH children should be developed and promoted as centres of specialisation with high levels of teacher training, service provision and accessibility. The role of the SNA in deaf education must be re-examined, in particular in cases where Deaf SNAs are employed as quasi-interpreters in the classroom and provide full access to the D/HH child to the curriculum. The potential for employing or promoting existing qualified ISL tutors working as SNAs to the role of language support workers should be examined. The withdrawal of SNA services based on Circular SP.ED 07/2002 as is happening at present should be halted immediately and examined by the National Council for Special Education. The level of staff training available primarily to those working in units and to a lesser extent those mainstream teachers with D/HH students should be examined on a national level with the intent of designing a series of in-service courses to up-skill teachers currently employed in the area. This could be designed as an extension of the current SESS model of in-service training.

An Irish Association for Teachers of the Deaf should be established to allow for more formalised communication between teachers nationally who are often quite isolated from others in their field. This association should be open not only to those working in the Visiting Teacher Service and units or schools for D/HH children, but to mainstream teachers, resource teachers, special needs assistants, ISL tutors and those working in the area of Deaf Education more generally.

Deaf Community Clubs and Organisations are encouraged to examine the role of the Deaf Community in supporting hearing parents with D/HH children and look into the possibility of providing a specific outlet for these parents facilitated by their existing organisations. Leading organisations such as the Irish Deaf Society may consider drawing up a parent liaison policy to accomplish this goal. More awareness needs to be promoted among the Deaf Community about the difficulties faced by hearing parents and the need to respect their choices regarding cochlear implants, hearing aids and speech training along with acknowledging that these decisions do not negate parents' desires to raise their D/HH child as a member of the Deaf Community and a user of ISL.

Being Deaf in the Mainstream?

The prevalence of the medical model underlines the fact that mainstreaming or integrating children who are D/HH is more a matter of equipping those children for a hearing and speaking environment, than it is about adjusting the environment to accommodate diversity and promote tolerance among children. Indeed, it could be claimed that mainstreaming, instead of *de*institutionalising D/HH students, is merely *re*institutionalising them; rearranging their spatial organisation away from the brick and mortar institutes of segregated residential schooling into a spatially dispersed institution of local schools, an institution which although it lacks the spatial delimitations of traditional institutions nonetheless remains overtly driven by institutional ideologies and a medical model of deafness.

The long term implications of this system are unclear, but one significant area of concern is that of language acquisition. It is thought that there is a critical acquisition period for language (Lenneberg, E.H., 1967) acquisition following which, if an individual has not secured a first language they are not likely to do so. For D/HH children without access to a full language, this is a very real danger. With the hegemonic medical system in place and D/HH children frequently denied access to Sign Language, we are putting all of our efforts towards speech, or all our eggs in one basket. Furthermore, while efforts are concentrated on speech, there are significant gaps in that service provision making this an uncertain approach.

In the absence of universal newborn hearing screening, D/HH children in this country are already identified late, and frequently have delayed language acquisition before any services are put in place. Add to this the lengthy delays both for audiology and speech and language therapy services, as well as the lack of continuity within these services once they begin, and the issue of language acquisition delay is further aggravated. For parents relying on the public health system, where approximately two 6-week blocks of speech and language therapy are sanctioned per year, contact with a qualified therapist may be limited to 12 hours each year. Those availing of cochlear implants who do not live within easy reach of Dublin, may return to an area where there is sparse speech and language therapy available. To promote a speech-only route in a system that is so under-resourced is to deny D/HH children the opportunity of full language acquisition. Delayed language acquisition, as has been highlighted in chapter 2 has a significant knock-on effect on literacy specifically and education generally. As a result, the situation facing this generation of D/HH children is likely to see effects through their adult life.

Another concern is that D/HH children will struggle in their identity formation as young adults while a medical model prevails, which forever views them as ‘not quite hearing’. As Davis and Watson (2001: 673) highlight

[i]n the case of some children the imposition of medically defined and adult-imposed notions of difference and normality lead to their identity only being described in terms of labels derived from the field of educational psychology,

and in the case of deaf children - audiology. While it was out of the scope of this thesis to examine in detail concepts of identity, others have noted the complex nature of D/HH identity and the important role of Sign Language as it “opened up the Deaf world for them to enter and become a part of” (Skelton, T. and Valentine, G., 2003a: 456). While parents of D/HH children may be able, to some degree, to shield their children from learning Sign Language, as these children grow up, they are likely to question those communication decisions made by their parents when they were younger. While there will be those who remain in the hearing world, using speech

for communication, there will be others who will transition to the Deaf world (Valentine, G. and Skelton, T., 2007), learning Sign Language and identifying as Deaf. For those making this transition, their relationship with their parents may suffer (Gregory, S. et al., 1995; Skelton, T. and Valentine, G., 2002) owing to the gap in communication between them. The persistence of a medical model which provides biased and inaccurate information to parents, therefore, could be damaging for many more years to come in terms of identity formation, parent-child relationships, and for the successful uptake of the Deaf Community's call for a socio-cultural model of Deafness.

Conclusion

Some children do not hear. This can be for a number of reasons: there can be a variation on a chromosome carried by both their parents, there may be a mechanical obstruction in their middle ear, their auditory nerve may not function, there may have been trauma experienced at birth, they may have been exposed to medication which causes harm to their aural faculties, or there could have been a viral or bacterial infection which left them with the inability to hear. As a result, these children will be marked out as different from their peers who can hear.

But this difference should be celebrated. The Deaf Community has long called for a social model of Deafness, which views it as a positive attribute bringing with it membership to a minority community with its own shared history, culture and language. This does not mean that D/HH children must live a life of isolation from their hearing peers. On the contrary, they can have membership to both 'worlds', moving daily between hearing and d/Deaf spaces, between hearing and d/Deaf societies, between family and community. Mainstreaming legislation in Ireland provided an opportunity for such inclusion to take place. It provided D/HH children with the option of attending their local school along with the provision of appropriate resources. Those resources could have been designed to allow hearing teachers and peers to learn methods of communicating with D/HH students, and to facilitate communication between both groups. It could have presented D/HH children with the opportunity to improve their spoken language acquisition while

ensuring that that goal did not become detrimental to their educational achievement, their social development, or their opportunity to develop a Deaf identity.

Instead, based on the results of participants in this research, the mainstream environment has become an opportunity for maximising spoken language acquisition alone, and is thus a continuation of the medicalization of D/HH children. Resources are provided almost exclusively by hearing professionals and concentrate on rehabilitating hearing loss through audiology and speech and language therapy. Where alternatives exist, such as the Irish Sign Language home tuition scheme, they are rarely promoted and instead act as a safety net in the event of a child 'failing' to acquire language. It is clear from speaking with parents of D/HH children that they desire speech for their child. But this is not an 'at all costs' desire, and many parents implemented the use of Sign Language on their own initiative to improve communication with their child. Were that decision to have been supported and facilitated by professionals in their midst, the situation facing those parents could be different. Instead, various modes of power are used to ensure that speech is the dominant method of communication used with D/HH children, often explicitly at the expense of Sign Language.

Prior to this thesis, the absence of academic inquiry into the deaf education system in Ireland has allowed at best, complacency and at worst, neglect to fester. The reluctance of various individuals within the Department of Education and Science to cooperate with the progress of this research indicates an overall sense of nonchalance about the situation as it stands. Always maintaining an air of neutrality and slow to make policy changes even in the face of undeniable international best practice, the Department has allowed deaf education to proceed practically unchallenged since it became involved in the Cabra schools in the 1950s. Parents are frustrated. The Deaf Community is angry. Many teachers are overwhelmed in their task of educating D/HH children. Medical and educational 'experts' can promote an almost exclusive medical approach to education to the detriment of a social model alternative. All the while, D/HH children continue to move slowly through the system within which they are embedded. All the while coping, but never quite reaching the potential they so deserve.

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Appendix 1: Details on research participants

Please note that the qualitative information provided in the tables below is minimal to preserve the anonymity of the participants.

Code	Details	School placement
Parent_01	Mother of Henry, who has a cochlear implant.	Full mainstream
Parent_02	Mother and father of Chris and Ellen, both deaf one with a cochlear implant, one with a hearing aid.	Full mainstream
Parent_03	Mother of Aine in secondary school but was in full mainstream primary.	--
Parent_04	Mother of a Marie who has a cochlear implant.	Full mainstream
Parent_05	Mother of Elaine, a preschooler. Elaine has multiple disabilities.	Preschool
Parent_06	Mother of a Daniel with multiple disabilities. Daniel is in secondary school.	--
Parent_07	Mother of Michael with a cochlear implant.	Full mainstream
Parent_08	A Deaf mother of Deaf children, ISL users.	--
Parent_09	Mother of Noel, who has multiple disabilities.	Full mainstream
Parent_10	Mother of Mark, a preschooler.	Preschool
Parent_11	Mother of Cormac who has a mild additional disability.	Unit
Parent_12	Mother of Jane who is in secondary school but was in full mainstream primary.	--
Parent_13	Mother of Darren, who has uses digital hearing aids. He is an ISL user.	Unit
Parent_14	Father of Salim. ESL household.	Unit
Parent_15	Mother of Joseph and Grace both deaf.	--
Parent_16	Mother and father of Amadi. ESL household.	Unit
Parent_17	Mother of Hazel who uses digital hearing aids. She is in secondary school after full mainstream primary.	--
Parent_18	Mother of Sean and Nuala, both deaf and in primary school.	Full mainstream
Parent_19	Mother of Leanne and Jessica, both deaf and in secondary school.	--
Parent_20	Mother of Paul, who has a cochlear implant.	Full mainstream
Parent_21	Mother and father of Conor and David, both deaf and in primary school.	--

Note: the symbol '--' is used for children whose school cannot be indicated to preserve anonymity of the participants.

Code	Profession
Prof_01	Undisclosed
Prof_02	Resource Teacher
Prof_03	Social Worker
Prof_04	Early intervention staff
Prof_05	Undisclosed
Prof_06	Special Needs Assistant
Prof_07	Unit Teacher
Prof_08	ISL Tutor
Prof_09	Mainstream Teacher
Prof_10	Unit Teacher
Prof_11	Mainstream Teacher
Prof_12	Resource Teacher
Prof_13	Unit Teacher
Prof_14_a	Unit Teacher
Prof_14_b	Mainstream Principal
Prof_15	Unit Teacher
Prof_16_a	Mainstream Teacher
Prof_16_b	Mainstream Principal
Prof_17	Mainstream Teacher
Prof_18	Mainstream Teacher
Prof_19	Unit Teacher
Prof_20	Unit Teacher

Interview Code	Children
Children_02	Chris and Ellen
Children_07	Michael
Children_21	Conor and David
YP_Focus Group	Jane, Aine, Maíre

Details

Both deaf, non-ISL users. One with a cochlear implant.
 Deaf, interviewed along with his hearing friend.
 Both deaf, interviewed along with their parents present.
 Three deaf teenagers, use both speech and signs.

Appendix 2: Sample Interview Structure from Parent Interviews.

The following is a list of sample interview questions. The interviews themselves were very informal and conversational in approach but the themes below were covered.

1. Tell me about how you found out that (name) is deaf?
 - a. In particular establish the length of delay between the first identification of a problem with their child's hearing, and the point of a final measured diagnosis?
2. After you found out, tell me about the few months that followed.
 - a. Find out in particular what services were provided?
 - b. Ask if counselling was provided.
 - c. Establish waiting periods for audiology and SLT.
 - d. Establish if parents have had to avail privately of services.
 - e. Establish if there is/was much travel involved in availing of services.
3. Did you receive any information about Irish Sign Language after diagnosis?
 - a. Find out in particular if a negative discourse of ISL was used by any particular service.
4. Do you use the ISL home tuition service?
 - a. In particular establish if parents are aware of the service.
5. How is communication in the home?
 - a. Find out in relation to immediate family
 - b. Find out about extended family
 - c. Ask about amount of time spent 'working' on language in the home.
6. If the family is using ISL: Have professionals (usually name audiology, SLT, VTS and cochlear implant team) supported you in learning ISL? (If yes, how?)
7. Did you find it hard to decide on what school to go to? Tell me about how you made that decision.
8. How did settling in at school go for you all?

- a. In particular find out about whether services had been set up in a timely manner.
 - b. Was there relative satisfaction with teaching staff and support staff?
 - c. Was a full time SNA provided?
 - d. No. of resources hours per week provided.
9. If you were working before you had (name), have you gone back to work since?
 - a. Establish if the additional care of a D/HH child is preventing one or both parents from returning to work.
10. How do you feel (name) is getting on academically?
11. How do you feel (name) is getting on socially?
12. Does (name) know any other D/HH children?
13. Have you had contact with other families with a D/HH child?
14. How much contact do you have with your Visiting Teacher now?
 - a. Establish if there has been much turnover in staff.
 - b. Check on whether there were waiting periods between staff being replaced.
 - c. Establish satisfaction levels with visiting teacher.
15. Have you thought about secondary school placement at all?
16. Would you have considered a different school placement option (usually specify unit or school for the deaf) if it had been local?

Appendix 3: Confirmation of Ethical Approval

NATIONAL UNIVERSITY OF IRELAND, MAYNOOTH
MAYNOOTH, CO. KILDARE, IRELAND



NUI MAYNOOTH
NUI MATHS

RESEARCH & GRADUATE STUDIES
Dr Carol Barrett
Enterprise Officer

Ms Elizabeth Sarah Matthews
Department of Geography
NUI Maynooth

25 October 2006

RE: Application for Ethical Approval for a project entitled:
Mainstreaming of Deaf Education in Ireland: an international comparative study

Dear Elizabeth,

The Ethics Committee evaluated the above project for ethical approval and we would like to inform you that ethical approval has been granted.

With kind regards

Dr Carol Barrett
Secretary to the Ethics Committee

Cc: Professor Robert Kitchen