CHAPTER 31

'NO SIGN LANGUAGE IF YOU WANT TO GET HIM TALKING': POWER, TRANSGRESSION/ RESISTANCE, AND DISCOURSES OF d/Deafness IN THE REPUBLIC OF IRELAND

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First published in *Population, Space and Place* (2011), 17, 361-376.

Introduction

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, 1960), cultural norms and values, and history (Groce, 1985; Bienvenu, 1989; Lane, 1989; Sacks, 1989; van Cleve and Crouch, 1989; Lane *et al.*, 1996; Mow, 2001; Woll and Ladd, 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 to lowercase deaf which signifies an audiological deficiency.[1] Although those identifying with the socio-cultural model of Deafness do not identify as disabled (Lane, 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, 1990). While this shift has occurred within the social and care sciences (including Geography) and Deaf Studies itself, with a transference from a medical model of disability to various kinds of social models, the predominant mode of research concerning d/Deaf people in medical and educational fields still favours the medical model of deafness as a disabling condition best corrected through audiological treatment and speech instruction (as highlighted by research reported in journals such as Audiology, International Journal of Audiology, the International Journal of Language and Communication Disorders, and The Journal of Speech, Language and Hearing Research). There is little room for the role of Sign Language or Deaf identity in this medical model, which instead prioritises acquisition of speech and integration with hearing society as the goal of deaf education. While due consideration must be given to the complexities of d/Deaf identity and the difficulties in implementing any

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[1] Throughout this paper, Deaf and deaf will represent socio-cultural and audiological interpretations of d/Deafness respectively. When one interpretation cannot be clearly identified, the term d/Deaf will be used. See Skelton and Valentine (2003a).

binary between deaf/Deaf or d/Deaf/hearing (Skelton and Valentine, 2003a) for the purpose of this paper, I will limit this discussion to the 'two dominant constructions of d/Deafness: medical deafness and socio-cultural Deafness (Valentine and Skelton, 2007: 108).

It is clear that this medical model, in Padden and Humphries (1988) terms, has a different 'centre' from that of their d/Deaf adult clients. As a result, d/Deaf 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'.

There are a number of possible reasons for the persistence of this medical model in spite of the progress outlined above, which I argue contributes to a hegemonic medical model of deafness. Firstly, there is a great deal of social authority attached to the medical fi eld (Wendell, 1996) which in turn attaches legitimacy to the medical interpretation of deafness. Secondly, there is a notable absence of d/Deaf people themselves from the medical and education fields where their presence could provide a counter balance to the hegemonic medical view of deafness currently prevalent. Thirdly, over 90% of d/Deaf children are born to hearing parents whose first interaction with d/Deafness is likely to be largely constructed by the medical field within which they receive diagnosis and early intervention (Skelton and Valentine, 2002; Valentine and Skelton, 2003). The medicalization of these families and their role or 'duty' in the production of 'healthy' children is also a significant factor in the continued hegemonic medical model of deafness.

One of the most obvious signifiers of the dominance of the medical model of deafness is the tentative position held both historically and con-temporarily by Sign Language in early intervention and education with d/Deaf children. This is particularly the case in the Republic of Ireland, the site of this study, where a number of specific policy factors[2] aggravate

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[2] Irish Sign Language has yet to be officially recognised as a national language by the Irish Government, a move which has already occurred under the British Government with respect to Irish Sign Language use in Northern Ireland. Ironically, the protection

the position of Sign Language over that in other countries. Sign Language lies at the heart of the social model of Deafness, indeed, one of the major instigations for Big-D Deaf was the work of linguist William Stokoe (1960) which proved that Sign Language (in this case American Sign Language, but his finding was generalised to apply to other Sign Languages) is a full language, with its own grammar and syntax. Its acceptance or rejection by hearing parents (as they are influenced by professionals in their midst) can therefore act as a signifier of socio-cultural and medical interpretations of d/Deafness, respectively. I will begin by examining the historical emergence of the social authority of medicine as it relates to deaf education, moving then to empirical evidence of the continuing medical hegemony in the Irish context. I will also examine instances of transgression/resistance to this hegemony from parents of d/Deaf children who implement Irish Sign Language as a method of communication for their d/Deaf children in spite of the medical model within which they are embedded. In light of Valentine and Skelton's (2003: 317) observation that 'it is learning [British Sign Language], and therefore being able to communicate with other d/Deaf people and to access the close-knit Deaf world, that is the most effective way for many young d/Deaf people to overcome social isolation and access the support of social network', examining how parents decide on and implement Sign Language use might contribute to our understanding of how best to foster resilience amongst young d/Deaf people and their families against the negative effects of marginalisation and hegemonic medical discourses of deafness. However, I will conclude by examining why this transgression/resistance is both spatially and temporally limited and unlikely, as it stands to make a significant impact on the system of deaf education.

Situating Irish Deaf Education In Geographies Of D/Deafness, Disability And Power

Skelton and Valentine (2003a) highlight that work on d/Deaf people has been absent from geography (although their research has come some way in addressing this lacuna) and that even within Deaf Studies, d/Deaf young people are frequently marginalised. This is also a dearth of contemporary work on deaf education in Ireland, perhaps owing to the small population of d/Deaf children and the absence of a national deaf education training programme. This paper therefore adds to the field of deaf education as well as to an emerging body of literature in geography and d/Deafness, and will specifically address the absence of work in the latter on issues regarding d/Deaf children. Previous research from geography on d/Deafness, has focused largely on young d/Deaf 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 the Irish language (Gaeilge) in government policy also has negative impacts on the Deaf Community, which will be discussed later in the paper.

of key interest (Butler *et al.*, 2001; Skelton and Valentine, 2002, 2003a, 2003b; Valentine and Skelton, 2003, 2007). While this work has flagged the significance of communication methods used during the d/Deaf child's upbringing as well as the influence of the medical model in influencing these decisions, it reflects on young d/Deaf people's views retrospectively of this period. This paper 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.

While the concept of power features in some work from Deaf Studies (Lane, 1992; Baynton, 1996; Branson and Miller, 2002; Ladd, 2003), it rarely extends to literature on communication choices amongst families and how concepts of power and resistance are played out between institutions and individual parents and children (for a notable exception see Komesaroff, 2008). Research is instead overwhelmingly empirical in nature, focusing on the descriptive experience of families as they choose one method or the other (Gregory *et al.*, 1995), the need for a family-centred intervention approach (Bodner-Johnson and Sass-Lehrer, 2003), or the causal relationship between home language and a number of other variables (Musselman *et al.*, 1996; McDonald Connor *et al.*, 2000). The focus on power in this paper, therefore, adds not only to Deaf Studies but also the growing body of literature in the geographies of power and resistance (Cresswell, 1996; Sharp *et al.*, 2000b; Rose, 2002; Allen, 2003; Jessop, 2007), as well as institutional geographies (Philo and Parr, 2000). It makes specific reference to Foucauldian Geographies, which have been a topic of debate in this journal (Legg, 2005; Philo, 2005), as it is Foucault's work on the rise of social medicine which frames this discussion. As such, it responds to Philo's (2005) call to 'enlarge the theoretical coordinates of population geography'. In particular, it examines how language is not only a mechanism through which power is reproduced and resisted (through discourse and ideology) as a means of controlling a particular population but can also be the target of those same tactics of power and resistance.

Furthermore, this paper broadens the current scope of population geographies to question the dynamic temporal and spatial aspects of particular populations, in this case d/Deaf children, and how their micro-movements, such as those between home and school, are embedded within a larger framework of socio-political goals. The educational, and indeed highly spatialised of mainstreaming children with special educational needs in their local school has come under examination from geographers (Kitchin and Mulcahy, 1999; Skelton and Valentine, 2002; Holt, 2003, 2004; Woolley *et al.*, 2006), but the links between this phenomenon and population geographies have, to date, been tentative. The fact that school choice is increasingly becoming a factor in move-ment and residential location of families (Butler, 2009) highlights the relevance of this area of study to population geographies.

The discussion is supported by findings from a doctoral research project on mainstreaming of deaf education in the Republic of Ireland. The findings presented here are from semi-structured open-ended interviews conducted with either one (usually mothers) or both hearing parents from 20 families with deaf children. At the time of the first interviews these children were aged between 18 months and 16 years with an average age of 8 years. While there has been much work recommending the inclusion of children's voices, especially marginalised children, instead of consulting parents or teachers on their behalf (Rose and Shevlin, 2004; Porter and Abane, 2008; Schafer and Yarwood, 2008), the consultation of parents in this research is justified in this context since the use and non-use of Irish Sign Language is largely due to decisions made in early intervention, when d/Deaf children are still infants. Subsequently, parents are the best sources of information regarding the issues surrounding communication choices in this early phase of their child's life. Parents were recruited through schools, contacts with the Deaf Community, and a series of five information nights held across the country aimed at promoting the research. Interviews with these parents ranged from half an hour to 2 hours and were conducted in spoken English, recorded using a Dictaphone, with the recordings transcribed and coded for analysis. Three of the families interviewed had migrated to Ireland while the remaining families all had at least one parent who was Irish.

The vast majority of children involved in the research were profoundly deaf. Approximately half of them used cochlear implants[3], while the other half used hearing-aids. All of the families, with the exception of one, began with an intervention path to provide speech to their children through medical intervention as opposed to using Irish Sign Language, with several warned outright against its use (discussed in detail below). Nonetheless, several of them went on to introduce their children to Irish Sign Language on their own initiative by learning through evening classes run by d/Deaf organisations. This is similar to findings from Gregory *et al.'s* (1995) longitudinal survey of parents with d/ Deaf children in the UK conducted in the 1970s and again in the mid-1990s. They observed that in spite of the fact that all of the children involved in their research began on a speech-only route, 39% of parents went on to learn British Sign Language and 38% of their child-participants (interviewed now as adults) stated that British Sign Language was their preferred language, with a further 16% nominating Sign Supported English.[4] The fact that Gregory *et al.'s* (1995) study included parents using a speech-only route in

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[3] A cochlear implant surgically implanted device which allows people with sensorineural deafness to access sound. Surgery must be accompanied by intensive therapy if speech is to be acquired.

[4] Sign Supported English refers to using speech that is combined with signs following English word order for clarification of meaning. It provides a visual reference for the English language and, unlike Sign Language, does not have its own grammar or syntax. Nonetheless, it indicates that a form of signing is used by these d/Deaf people in Gregory *et al.'s* (1995) study.

the 1970s however highlights that Ireland is still a good deal behind the UK in terms of policy and practice of deaf education.

The UK, amongst other countries has reintroduced Sign Language to some degree in the wake a resurgence in the use of Sign Language during the 1970s and 1980s following research into the success of Deaf children with Deaf parents (and thus Sign Language users) compared with deaf children with hearing parents (non-users) (Easterbrooks and Baker, 2002). This gave rise to the bilingual-bicultural movement in deaf education which seeks to establish Sign Language as the first and natural language of d/Deaf children before progressing to teaching a second language (e.g. English) through Sign Language. This system has been implemented in some schools across Scandinavia, the UK and the US to name a few. Skelton and Valentine's (2002) work highlighted that these bilingual policies in the UK have dispelled the negative myths about d/Deafness and Sign Language and aided a shift in attitudes in deaf education. This movement has yet to make much ground in Ireland, however, the causes of which will be discussed later.

Subsequently, while the medical model may have been more overtly challenged elsewhere, its prevalence is still very much felt in the Irish context, particularly in the organisation of early intervention services in relation to the use and non-use of Irish Sign Language. The Irish health and education systems may therefore provide a more visible example of how a hegemonic medical model is reproduced, and these overt examples may still have relevance elsewhere where the medical model, though challenged, still holds significant (though more covert) authority, in particular since the increase in cochlear implantation could once again see a rise in speech-only recommendations.

Power And The Social Authority Of Medicine

There has been re-emergence in discussions around institutional and organisational geographies in recent years (Crang, 2000; Del Casino *et al.*, 2000; Philo and Parr, 2000) as well as an analysis on the complexities of power relations embedded within those spaces (Crang, 2000). Throughout these debates, it is now widely recognised that power is a relative concept, contingent on temporal and spatial conditions rather than being something that is intrinsically held within institutional spaces. Furthermore, the reproduction and contestation of discourses emerging from those spaces involves an intricate negotiation between processes of power and resistance. These processes, complex in nature, are contingent, relative and productive forces, in a continuous state of 'becoming' through the various contexts in which they are embedded. Power, in this complex nature, cannot be understood simply as an all-encompassing dominating force over an oppressed populace. Nor can it be examined as 'centred' (Latour in Allen, 2003), something intrinsically 'held' in institutional spaces, or by high-ranking professionals. Rather, it must be examined as a relational effect of social interaction where power

in its various guises (domination, coercion, manipulation, seduction, inducement, negotiation, persuasion) is engaged in a constant struggle with resistance in its numerous forms (non-consent, non-cooperation, disobedience, protest, persuasion) (Allen, 2003), producing a complex entanglement of power/ resistance (Sharp *et al.*, 2000a).

Nonetheless, organisations (or 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 limit what is thought, as well as a what is thought to be possible' (Del Casino *et al.*, 2000: 526). In the case of the institution of medicine, and the organisations/hospitals embedded within that institution, their power to measure, diagnose, and categorise d/Deaf children's hearing impairment gives them priority with hearing parents who must obtain this diagnosis if they are to acquire any services for their child. This also applies to other children with disabilities. This power to measure, know and explain hearing impairment is embedded within a long history of the social authority of medicine. As Foucault states:

> 'In the patient eyes, the doctor becomes a thaumaturge; the authority he has borrowed from order, morality, and the family now seems to derive from himself; it is because he is a doctor that he is believed to possess these powers … [the patient accepts] entirely and in advance all his prestige'. (Foucault, 1965 in Rabinow, 1984: 163)

As a result, the social authority of medicine and the subsequent respect and trust that parents place in doctors is the starting point for examining how a hegemonic medical model of deafness is established and reproduced. This social authority gives legitimacy to the medical model and can be contrasted with the lack of legitimacy afforded to the Deaf Community (for examples on this lack of legitimacy in the public media see Winterson, 2002; Young, 2006). In examining this issue, I will focus on the work of physician Jean Marc Gaspard Itard at the National Institute for Deaf-Mutes in Paris to exemplify the origins of the medical model of deafness, and the authority of the doctor in steering deaf education (Lane, 1976).

Itard began working at the Institute in 1800, at a time when the field of medicine had been firmly established across Europe. Foucault traces the development of the social authority of medicine and doctors in particular during the previous century stating 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, 1980 in Faubion, 2002: 100). Much of this authority is embedded in the fact that from the 18th century onwards, science places an increasingly significant emphasis on the normalisation of bodies, and doctors are the chief individuals responsible for identifying, categorising,

and eradicating deviance amongst those bodies. This culminates in the fact that

> 'the 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 1980 in Faubion, 2002: 100)

This social authority meant that, in spite of the fact that Itard never learned Sign Language in his 40 years working at the Institute, and that he consistently worked with very small numbers of the school population for a limited time each day, the claims he made about deafness carried great legitimacy not only in the running of the Institute but in the implementation of deaf education across much of Europe and the US (Lane, 1976). Most controversially, and relevant to the discussion at hand, Itard predicted that better success could be achieved in oral training if students were isolated from Sign Language, signalling the beginnings of a negative discourse of Sign Language:

> '[We must] allow no means of communication other than spoken language between the hardof-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'. (Lane, 1976: 204)

> 'exclude the use of sign language and … oblige the students and the professor to communicate among themselves only by speaking or by the intermediary of writing. It is of the greatest importance that, at this final stage of instruction, the deaf-mute should *cease thinking on his inherently defective and abbreviated language* in order to translate his ideas into our own, as he is in the habit of doing this'. (Lane, 1976: 240 emphasis mine)

While Oralism swept across Europe and the US throughout the late 19th and early 20th century, it was much later when the Irish education system came on board. While the slow uptake of Oralism has been attributed to the isolation of the Catholic orders involved in deaf education (Crean, 1997) as well as economic factors (McDonnell, 1979), it is also very likely that the dominance of Catholicism as a social authority over that of medicine in early 20th-century Ireland was a significant factor in maintaining Sign Language as a means of instruction for d/Deaf students, a method which was always favoured by religious orders (Baynton, 1996). Nonetheless, Oralism gained ground around the 1950s and soon tactics such as surveillance, segregation, negative discourse were being used to discipline children (Saunders, 2004 lists signing as a 'sin' to be confessed in the school for d/Deaf girls in Dublin). The fact

that those students throughout this Oralist period who could not acquire speech were segregated from their classmates, labelled as 'oral failures', and kept in the junior section of the school highlights the negative attitude towards Sign Language during this time (personal communication Deaf Community). Failure to acquire speech was also at times attributed to perceived intellectual disability (Department of Education, 1972) as opposed to any fault with the methodology of instruction. The Oralist system implemented in the 1950s continued with little challenge up until the 1980s when a limited amount of Sign Language began to reappear, out of necessity, in the schools for the Deaf (personal communication, teacher of the deaf).

In spite of this minor resurgence in Sign Language, the deaf education system in Ireland is still for the most part an Oralist system, and has not seen the benefits of bilingual education policies instigated elsewhere. Oralism remains particularly strong since the overwhelming majority of d/Deaf children are in place in mainstream schools, where access to Irish Sign Language is very limited (discussed further below). Since Oralism is entrenched in the medical model, doctors and other medical professionals (such as audiologists, speech and language therapists and psychologists) continue to hold great authority regarding educational interventions for d/Deaf children. These professionals are now the fi rst port of call regarding not only diagnosis, but the means of early intervention to be pursued, appropriate educational placement, and communication choice. These services are framed within a medical discourse of deafness, prioritising the acquisition of spoken language, to which Sign Language can be seen as a threat.

Silencing Deafness: The Exclusion Of Deaf Adults
The prevalence of the medical model of deafness and the legitimacy of this model is aggravated by the absence of Deaf adults from the medical and educational (Moores, 2008) professions internationally. Ireland has particular difficulties in this area whereby policy measures mean there is almost a complete absence of teachers who are themselves d/Deaf working in the primary deaf education system. Proficiency in the Irish language (Gaeilge) is required to become a qualified teacher at primary school level. However, d/Deaf people are exempt from learning Irish while at school, subsequently disqualifying them from enrolling in many teacher training programmes later on. Gaeilge is not required for second level teaching, and a small number of d/Deaf people have succeeded in becoming teachers at this level. However, since this research focuses on early and primary education, the presence of these teachers at second level is not examined. Subsequently, hearing professionals not only overwhelmingly outnumber d/Deaf professionals in the medical arena (as they do in most other countries), but also almost completely within the early education sector.

As well as the absence of d/Deaf teachers, hearing teachers are not required 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 to intermediate level) they would by no means qualify as Sign Language role models to the extent that native/fluent signing Deaf adults would. As a result, the use of Sign Language in classrooms across the country is limited to the haphazard training acquired by hearing teachers. As a tokenistic recognition that this situation is unsatisfactory, Deaf adults will occasionally be employed in the capacity of special needs assistants to work with d/Deaf children who need access to Irish Sign Language in the classroom. However, this role as assistant carries with it a distinct power dynamic whereby Deaf adults are subservient to the hearing teachers with whom they work.

Several hearing teachers interviewed over the course of this research spoke of tensions between themselves and Deaf staff as the teacher felt their authority was being undermined:

> '[My principal tells me] "you just have to put the foot down and say it" and I go "I know" … "you have to show her *you're* the teacher, *you've* been trained." [The special needs assistant] "didn't study, didn't go to college. You've done all of this." ' (Teacher 13)

As a result, while the hearing teacher may have difficulties communicating with their d/ Deaf students who use Sign Language, and may have no experience or training in deaf education, the Deaf adult must concede to their authority because, unlike the hearing teacher, they do not have a university degree to legitimise their role in the classroom.[5] As a result, the value of having a native Irish Sign Language role model in the classroom, as well as someone with first-hand experience of Deafness and the deaf education system is undermined in favour of a model which prioritises spoken language, hearing professionals and the authority of the medical model.

This absence of Deaf adults allows for the monopoly of the medical model to continue. It also limits the potential impact of international developments in deaf education, such as the bilingual movement mentioned above. Since bilingual education for d/Deaf children requires native or fl uent Sign Language role models, and these are absent from the Irish education system, this model has yet to make ground in Ireland.

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[5] It might be of interest to note that a number of Deaf special needs assistants do not have degrees in education but hold third level qualifications in other areas, occasionally to Masters level, but these qualifications do not entitle them to teach. They are subsequently on a significantly lower salary than paid teachers and hold authority in the school.

It also leaves families of d/Deaf children in a position whereby they are very unlikely to encounter a Deaf professional while making decisions for their children's communication, a situation aggravated by gate-keeping of information and the creation of a negative discourse of Irish Sign Language by hearing professionals.

Gate-Keeping, Power Relations, And The Negative Discourse Of Irish Sign Language

> 'The family 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, 1980 in Faubion, 2002: 96)

In *The Politics of Health in the Eighteenth Century*, Foucault (1980 in Faubion, 2002) cites childhood as problematic, a phase within which to secure an optimal and healthy development. It is the family which becomes the pivotal source of securing the production of healthy children, as set down by the (Medical) State. Foucault refers to this move as 'the privilege of the child and the medicalization of the family' (1980 in Faubion, 2002: 96). The family environment became one which is 'dense, saturated, permanent, continuous … that envelopes, maintains, and develops the child's body' with the health of children becoming 'one of the family's most demanding objectives' (1980 in Faubion, 2002: 97).

It is the hearing family, through the advice of medical and education professionals (from which Deaf people are excluded) that steer the 'healthy' development of d/Deaf children. For the vast majority of hearing parents, the birth of their d/ Deaf child will be their first interaction with deafness. Therefore, as Gregory *et al.* highlight 'advice from professionals carries a lot of weight, especially with a group of parents of deaf children who may not know other parents in a similar position and thus have nothing with which to compare the advice they receive' (1995: 49). In addition to this, to counteract parents accessing information through their own research or chance encounters with the Deaf Community, gate-keeping of information, as well as tactics of power such as seduction, inducement, and coercion used by these professionals through the creation of a negative discourse of Sign Language all come into play. It is important to highlight that this exercising of power as it relates to deaf education is heterogeneous and context dependent, with individual variation across professionals and parents causing variation in the advice/ direction given, the manner in which it is given, and the reaction from parents. However, general observations can be made indicating the tactics used to maintain the hegemonic medical discourse on deafness.

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. In Ireland, parents are officially provided with the 'choice' of teaching speech or Irish Sign Language to their child with speech and language therapy and Irish Sign Language Home Tuition services provided respectively. However, while parents are officially given these 'options' this research saw evidence of gate-keeping of access to information about Sign Language. Many of the parents involved in this research were not informed of the benefits of using Sign Language with their deaf children:

> 'I don't think we were even, I can't even remember if they even asked me "do you want Sign Language?" '. (Parent 02)

Instead, early intervention services revolve around the continuous use of hearing aids, the possibility of cochlear implantation, and the provision of speech and language therapy. *All* of the parents receiving a diagnosis in Ireland were immediately provided with hearing aids, advised regarding cochlear implantation when appropriate, and referred for speech and language therapy (although long waiting lists for this service persist). Parents are seduced into the medical model with the sometimes misleading promise that their child will acquire speech:

> 'You know, you were just sent home with hearing aids on and … you just have to get him talking and 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)

On the other hand the Irish Sign Language Home Tuition service was often not promoted or even advertised by those responsible for informing parents (the Visiting Teacher of the Deaf). Over 25% of the parents interviewed for this study had never heard of this service at the time of the interview. Of the remaining 75% of parents who knew about the service, only two of them had been told by the visiting teacher about the service with the remainder finding out through their local Deaf organisation which they approached independently:

> Interviewer: How was communication in the house then at that point, were you all, em, learning Sign Language? [Mother nods] Was that the way that, is that what the Visiting Teacher Service again sort of recommended?

> Mother: No, I did this off my own … And it was actually a girl, she's a Special Needs Assistant who used to look after Noel, her friend eh, was looking after a girl who was deaf

from [name of town]. And it was through her that we found out. Otherwise we wouldn't have known anything about classes or anything. (Parent 09)

Subsequently, the 'choice' that parents make to use speech over Sign Language is often guided by limited access to information on the benefits of Sign Language and information regarding services available in Sign Language.

For many parents however, 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, the power of seduction wears off. Also, as their shock after diagnosis wears off and parents begin to proactively research deaf education, perhaps engaging with their local Deaf organisation, the use of Sign Language becomes more of an option. To maintain non-use of Sign Language, a second tactic, inducement, becomes implemented. Here we begin to see a small element of force, often appealing to common sense on the practicality of speech, and parents are won over to the advantages of their 'choice' and subsequently cease to resist and fall into line (Allen, 2003: 101):

> 'And eh …o they were recommending that we didn't teach Hazel[6] 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)

This is combined with coercion, whereby if parents continue to resist, negative sanctions are threatened or imposed until they comply (Allen, 2003: 31). The negative sanctions in this case are implicit and psychological, by incorporating a negative discourse of Sign Language whereby parents run the risk of 'damaging' their child 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 and it could set him back a lot, that's what the new teacher for the deaf was telling me'. (Parent 02)

Sign Language, instead of being upheld as a valuable mode of language acquisition for d/ Deaf 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'. (Parent 04)

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[6] The names of children and parents in this research have been replaced to conceal their identities.

'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 (gestures 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 amongst parents who wish to provide their children with the 'opportunities' available through speech in a hearing world and avoid jeopardising that through use of Irish Sign Language. For parents who are struggling to implement the speech-only route, yet aware of the negative sanctions of using Sign Language, there are a number of tactics provided to help prevent signing, such as ignoring their child when they signed, encouraging them to speak instead of sign, or restraining themselves while they communicated with their child:

'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)

'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)

Many of the parents recounted stories like this, signalling the relative success of the hegemonic medical model in implementing a speech-only route. It is interesting to compare these findings once again to those mentioned by Gregory *et al.* (1995) in their research during the 1970s, which found parents being warned off Sign Language as it caused 'laziness' and prevented speech from developing, indicating the use of similar tactics in the UK almost 40 years ago. However, it also emerged that there was an element of resistance to this system. In spite of the fact that almost all of the parents in Gregory *et al.*'s study started on a speech-only route, only one family continued on that route without ever learning Sign Language with all other families using Sign Language at some stage in their child's development.

Resistance/Transgression And The Necessity Of Irish Sign Language

Acts of resistance, as Rose (2002: 383) states 'strategically subvert, appropriate, and contest hegemonic spaces and the dominant relations they stand for', subsequently the use of Irish Sign Language by parents in spite of the hegemonic medical model within which they are embedded could qualify as such an act. However, Valentine and Skelton (2003: 314) 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'. Similarly, there is the danger of romanticising resistance (Cresswell, 1996), viewing *any* incidents of parents using Irish Sign Language as an act of resistance when in fact they frequently lack an intentional motivation to 'strategically subvert' the medical system. These acts could instead be viewed as transgressions, unintentional in nature yet with a visible result that counteracts the intentions of the dominant group, in this case medical and educational professionals (Cresswell, 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)

Therefore, while strategic acts from the Deaf Community such as organising protests, Sign Language pride marches, or active promotion of the use of Sign Language amongst parents might be considered resistance, the actions of parents is often framed, not as an ideological struggle but rather out of practical necessity within the home. It has, nonetheless, the potential to develop into resistance. Therefore, I refer to these as acts of transgression/resistance signalling not only the difficulty in distinguishing between these acts, but also the fluidity from acts of transgression to acts of resistance over space and time since these acts are frequently spatially and temporally limited, often being confined to early childhood before spoken language has developed and occurring only in the family home. 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/Deaf children as they try to negotiate the everyday implications of a hegemonic medical model.

The forms of transgression/resistance evident in this research were non-compliance, protest, and public revelation. Non-compliance was frequently cited on the grounds that following a speech-only route with their young d/Deaf child simply was not practical, with frustration cited

as the most common reason for opting for Sign Language.

> '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)

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 from professionals. However, pragmatic resistance was often accepted by medical professionals, although it was usually 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/Deaf children. In the case of the mother 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)

Outright protest was less common amongst parents, 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:

> Interviewer: Have you had any sort of conflict with, with going to [hospital name], 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?
>
> Interviewer: yeah, have..?
>
> Mother: (interrupts) no.
>
> Interviewer: 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'.
>
> Interviewer: 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 …

Interviewer: so they [the cochlear implant team] had no problem with it at all?

Mother: oh no problem with it whatsoever (Parent 05).
'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, em, I want him to have it'. (Parent 10)

As a tactic of resistance, this seemed to be the most successful with parents encountering little in the line of coercion or inducement from medical and educational authorities. Nonetheless, there are negative implications felt by parents who use Sign Language as a method of communication. Most notably, the choice of educational placement becomes limited as Irish Sign Language interpreters are not provided in mainstream schools.[7] The only Deaf parent interviewed for this research recounted her experience in trying to secure a mainstream education for her child. She was refused a Sign Language interpreter on the grounds that she could send her son to the school for d/Deaf children if she wanted his education to be conducted through Irish Sign Language. With only one residential school for d/Deaf boys in the country, this is a difficult decision to make and places restrictions on those parents wishing to use Sign Language as the primary mode of communication with their child.

Parents of older d/Deaf children in this research were more likely to resist in an intentional and collective fashion, informing other parents of the value of Irish Sign Language or campaigning for access to and information about Irish Sign Language, perhaps out of growing confidence as parents of a d/Deaf child as well as recognising difficulties their d/Deaf children are experiencing. Several parents with older d/Deaf children spoke of using the research itself 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'. (Parent 17)

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[7] As was mentioned earlier, occasionally a d/Deaf person will be employed as a special needs assistant to work with deaf children who use Sign Language in mainstream environments. However, this is not directed by or guaranteed in policy, and is actually contrary to the requirements of special needs assistants that they refrain from engaging in any educational role. Furthermore, with the recent educational cutbacks special needs assistants are being removed from d/Deaf children. Subsequently, the place of Irish Sign Language continues to be undermined in the deaf education system.

A number of these parents with older children were quite adamant and angry that they had been misled about the use of Sign Language, yet they had not directly tackled those responsible.

> '[Y]ou know, that was a complete, that was a huge mistake. She should have been helped, she should have had Sign Language right, all the time'. (Parent 17)

> '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 d/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)

> 'As soon as I saw the children [at an event for d/Deaf children] using all the different [modes of communication], I just said "that's ridiculous!" . . . you know what's the point of trying to force something [speech-only] on her if it's not going to work?' (Parent 05)

> 'Em, 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 in [an event for d/Deaf children]'. (Parent 06)

Once again, Gregory *et al.'s* study also highlighted a great deal of resentment from those parents who had been badly informed in the 1970s regarding the benefits of Sign Language. One father of a Deaf adult man said 'We ought to have been taught to sign and we ought to have been encouraged to sign from the word go' (Gregory *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 this research unfair, it should be observed that three of the four 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 grow.

Noticeably, however, 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 authority of the medical model. The fact that these parents did not directly confront the system may be due to the fact that all of the hearing parents interviewed are still within medical and educational services, and may be uncertain about challenging the system upon which they are so reliant, signifying the authority held by these services in their ability to grant or deny easy access to services. Therefore, while parents use trans-

gression/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:

> '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 life-raft, 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)

Overall, while there are individual acts of transgression/resistance from parents, these acts are often spatially and temporally constrained and lack a collective and intentional challenge to the system. Where parents feel they have been let down by the system, and there is the possibility of 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. Parents rely a great deal on the scant services provided 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

While power is complex, heterogeneous and context dependent, and any seeming hegemony is unstable and comes with the possibility of resistance, the Irish deaf education system in its present state is characterised by a robust hegemonic medical model. 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/ Deaf children. The hegemonic medical model must be viewed within the context of a long history of the social authority attributed to medical and educational professionals, which legitimises their goals, in spite of their limited 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.

Several tactics are used to reproduce and maintain this hegemony, including gate-keeping access to information about Sign Language, seduction, inducement and coercion of parents into using a speech-only approach, and excluding Deaf professionals through policy measures thus maintaining a monopoly of power amongst hearing professionals. Thus, as Allen (2003: 26) observes 'some people and some groups have more power than others, not by accident or by a series of fortunate events, but by virtue of the structure of relations of which they are part'. However, Allen also states that power is relative and is frequently met with resistance.

In spite of the system within which they are embedded, and the tactics described above, many hearing parents of d/Deaf children in Ireland still continue to choose Irish Sign Language as a means of communicating with their child. 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, 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 more so the case now than before because of the mainstreaming movement taking place. Subsequently, the nature of transgression/resistance from parents in introducing Irish 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.

This is further aggravated by the fact that the overwhelming majority of d/Deaf children (90%) are in place in mainstream schools, limiting their interaction with d/Deaf peers as well as the interaction of their parents with other parents of d/Deaf children. This lack of collective action is changing the potential geographies of resistance within deaf education. While residential schools for d/Deaf children have long been heralded as bases of resistance where Deaf Culture and Sign Language is transmitted from one generation to the next, often in spite of anoralist philosophy in place within the school (Ladd, 2003), the mainstream environment limits this intergenerational contact. Furthermore, deafness is usually only one generation thick, with most d/Deaf children having hearing parents, and most d/Deaf parents having hearing children. Subsequently, collective resistance through family networks is restricted to the 10% of d/Deaf people born into d/Deaf families. It is for this reason that mainstreaming, rather justifiably is often viewed as '[destroying] the embryo of the Deaf Community' (Crean, 1997: 128), as it limits not only the interaction of d/Deaf children amongst each other, but denies the development of information networks and collective action possible amongst their parents.

The long-term implications of this hegemonic medical system are unclear, but it is likely that d/Deaf children will continue to struggle in their identify 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 paper to examine in detail concepts of identity, others have noted the complex nature of d/Deaf 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 and Valentine, 2003a: 456). While parents of d/Deaf 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 and Skelton, 2007), learning Sign Language and identifying as Deaf. For those making this transition, their relationship with their parents may suffer (Gregory *et al.*, 1995; Skelton and Valentine, 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.

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