CHAPTER 1

⌒

Introduction

Sᴏᴍᴇ ᴄʜɪʟᴅʀᴇɴ do not hear. This can be due to a number of reasons: variation on a chromosome carried by both parents, an obstruction in the middle ear, a nonfunctioning auditory nerve, birth trauma, medication that harms the aural faculties, or a viral or bacterial infection that damages the inner ear. As a result, these children are often marked as different from their peers who can hear.

Language, Power, and Resistance: Mainstreaming Deaf Education is about these children. More precisely, it is about deaf and hard of hearing (DHH) children in Ireland, their families and teachers, and their experiences in the education system.[1] Readers from Ireland will be particularly interested in this book, because little research has been done on DHH children's lives in that context. However, international readers will also find the subject matter of interest for a number of reasons. First, this book examines

---

1. Throughout this book, the term *Ireland* is used to refer to the 26 counties of the Republic of Ireland. When discussing the historical context of deaf education, it is important to recognize that the Republic of Ireland was declared in 1949 following its independence from the United Kingdom in 1922. Subsequently, references to the history of deaf education in Ireland that predate 1922 are understood to mean Ireland as part of the United Kingdom. Readers should keep in mind that the six counties of Northern Ireland following 1922 fall under a different education system, and that system is not reflected in this book.

the phenomenon of mainstreaming deaf education, moving away from a traditional model of segregated education in schools for the deaf. Rather than examining the academic or social outcomes of that movement, this book looks at why and how DHH children are mainstreamed. In particular, it examines the impact that mainstreaming has on language use for families and subsequently, as we will see, the prevailing discourses surrounding d/Deafness. Second, it places this discussion in the context of deaf education history, both international and Irish, and covers the debates over DHH people's language use through the centuries. The history of deaf education in Ireland is particularly interesting in this regard, because, unlike in the United States, Ireland's largest schools for the deaf continued using sign language as the dominant method of instructing DHH children up until the late 1940s. Finally, *Language, Power, and Resistance* frames this discussion as one of power relations across parents, children, and professionals working within the system. It looks at how various forms of power are used to influence decisions, resist decisions, and shape the structure and delivery of deaf education nationally in Ireland. Although the book uses Ireland as an example to illustrate these themes, international readers are likely to find some resonance based on their own experiences.

Across different times and places, children who do not hear have been called *deaf* or *Deaf*, *deaf and dumb*, *mute*, *hearing impaired*, and *hard of hearing*; however, the most noticeable aspect of their difference from others is the difficulty they experience in acquiring spoken language. This presents a number of subsequent difficulties, namely in communicating through spoken language, acquiring literacy in the written versions of spoken languages, and subsequently, in accessing conventional education systems. As a result, over the last couple of centuries, there has been a growing preoccupation within the education field with the "best" means of eradicating the complications of deafness and improving the social and academic outcomes of these children. For a long time, the primary pedagogical approach was to adapt the medium of teaching by using sign language, a visual means of communication that was accessible to DHH children, and following a philosophy known as *manualism*. However, over time, this ideology was challenged by a philosophy known as *oralism*, whereby DHH children would learn how to communicate and subsequently be educated through spoken language and listening, with the goal of integrating them

into hearing society. Oralism was often (although not always) accompanied by an opposition to the use of sign language, which was viewed as a barrier to acquiring speech. Although 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. This debate "was not, for [teachers of the deaf] or for most deaf people, whether oral communication should be taught. The fight was over sign language" (Baynton 1996, 14). These debates reflect the contrasting desires for DHH children to be normalized, integrated, and assimilated within mainstream society, where they could live and work among hearing people, versus being inducted into Deaf culture through the use of sign language, where they could live alongside, but perhaps not truly within, hearing society. As such, the debate has deep ideological roots based on contrasting models (namely medical and social models) of what it means to be a child who does not hear.

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 center in the brain. Because the medical model equates deafness with an inability to hear, overcoming deafness involves rehabilitating the hearing organs. Often, this comes in the form of amplification (using hearing aids) or surgery (e.g., 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 the oralist philosophy.

On the other hand, over time, recognition that Deaf people comprise a Deaf community, which shares a common language, sign language, with its own grammar and syntax, cultural norms, values, and history, has highlighted the need for a new social perspective on Deafness that breaks away from the traditional medical view of hearing impairment (Lane 1989; Lane, Hoffmeister, and Bahan 1996; Sacks 1989; Van Cleve and Crouch 1989; Woll and Ladd 2005; Groce 1985; Bienvenu 1989; Mow 2001; Stokoe, 1960). This rise of the social model of Deafness, sometimes known as *Big-D Deaf*, is signified by the capitalization of the word *Deaf*, indicating membership to a cultural and linguistic minority group, as opposed

to lowercase *deaf*, which signifies an audiological deficiency. Although those identifying with the social model of Deafness do not identify as disabled (Lane 2002), the progress made in establishing a social model must be situated within a general shift away from viewing disabilities as inherently personal obstacles, toward one that examines the role of the physical, social, economic, or political environment in creating disability (Oliver 1990). Although the social model of Deafness is a phenomenon of the late 20th century, many of its key features (the congregation of Deaf people in communities, the use of sign language) are much older and were part of the historic debates over how DHH children should be educated.

Until the 1970s, the dominance of one viewpoint over the other was played out in schools for the deaf. Particular schools favored manualism or oralism, and shifts occurred in response to changing social conditions. One consistent feature of this educational system, however, was that DHH children had the opportunity to interact with their DHH peers, supporting the development of the Deaf community and the intergenerational transfer of a social model of Deafness. This fostered the growth of sign languages, often regardless of the philosophy of the particular school. Adults in the Deaf community lobbied for their rights and the rights of DHH children. As a result, regardless of whether or not the education system promoted a medical view of deafness, the congregation of DHH children and the subsequent rise of Deaf communities secured the continued alternative, social model of Deafness. From the 1970s onwards, however, deaf education changed with the arrival of what became known as *mainstream* education. At the time, the integration, or mainstreaming, of select DHH children into public schools relied largely on the good will of teachers in those schools and the success of individual children in acquiring speech. Those children unable to acquire speech would be candidates for schools for the deaf and for sign language use. Thus, it remained the case that there were identifiable candidates for one system or the other. However, in the 1970s, pioneered by the United States, a new philosophy would emerge whereby nearly *all* DHH children were deemed potential candidates for mainstreaming into public schools, with only the very few remaining children seen as suitable pupils for schools for the deaf. This philosophy, spurred on by the gains made during the American Civil Rights movements of the 1960s and 1970s (Moores 1992), was supported by a number of legislative moves, beginning with Public Law 94-142, the Education

for All Handicapped Children Act, in the United States in 1975. As a result, the intergenerational transfer of the social model of Deafness was no longer guaranteed, because generations of DHH children simply did not meet in schools. At this point, the medical model started to emerge as the dominant or *hegemonic* way of understanding what meant to be DHH.

In Ireland, this move to mainstreaming in policy would happen considerably later, with the Education Act of 1998 (Government of Ireland 1998) and the Education for Persons with Special Educational Needs Act (EPSEN) of 2004 (Government of Ireland 2004), although in practice, children had already begun to move into that educational environment. Approximately 78 percent of DHH children in the Ireland are now educated in mainstream settings (National Council for Special Education 2011), reflecting broader international trends to mainstreaming. Enrollment in schools for the deaf has been in significant decline during the same time period. As a result, the spatial organization, or geography, of deaf education has changed. Once centrally organized in schools for the deaf, DHH children are now spatially dispersed from each other for the first time since systematic deaf education began. This change has come despite concern that mainstreaming may be particularly unsuitable for DHH children (United Nations Educational Scientific and Cultural Organization 1994). Although mainstreaming has certainly produced some positive outcomes, particular concerns have been raised (and will be further discussed in chapter 2) over educational attainment, social isolation, ideological foundations, the lack of appropriate services, and the lack of specialist training among staff in mainstream settings. This book examines how and why, despite this, DHH children are mainstreamed.

Terminology

Terms used to refer to DHH 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, when used in this book, the term *deaf* refers to an audiological deficiency, whereas *Deaf* refers to membership in a minority community, the Deaf community, and the use of sign language for communication.

Although the terms *hearing impairment* or *hearing loss* are still commonly used by many hearing people, including a number of parents involved in this research, they can be seen as offensive to the Deaf community, because they refer to the medical model of deafness, which views deaf people as deficient. The Deaf community highlights this by juxtaposing the term *hearing loss* with the term *Deaf gain* (Bauman and Murray 2009). As such, the terms *hearing loss* and *hearing impairment* are only used in this book when appearing in direct quotations from interviews or where used specifically in relation to the medical model of deafness. I use the term *discourse* to refer to "clusters of assumptions and meanings" (Harris 1991, 672).

Although the vast majority of the children involved in this research were profoundly deaf, the term *deaf or hard of hearing* (DHH) is used throughout the book to give due weight to the 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, Ower, and Goldstein 2002). This process of self-identification, or of naming by others, is multifaceted and complex. I acknowledge that collapsing the continuum of possible identities and the fluidity of such identities over time and space into a simple and somewhat binary "DHH" is problematic. Although it is beyond the scope of this book to unpack these complexities, I have attempted to reflect this continuum through DHH, using all capital letters, allowing for the fact that this identification may be cultural, although 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 capitalization of letters will be used.

The term *sign language* is capitalized when referring to languages of a given nation (e.g., Irish Sign Language, American Sign Language, with respective abbreviations, such as ISL and ASL). These are not simply visual representations of spoken languages but are all languages in their own right with their own linguistic structure. They are distinct from each other; sign language is not universal. Signed English, on the other hand, refers to a manual system that places signs (often borrowed from sign language) in English word order.

The usage of the term *inclusion* in the deaf education setting has become more common than the use of *integration* in recent years, reflecting

a shift from a needs-based to a rights-based agenda. However, in practice, the distinction between these two terms is not always clear (Lindsay 2007). For some, the distinction is one of placement, in particular where students receive additional support. In this regard, one of the distinguishing features between integration and inclusion is the practice in the former of withdrawing children from the mainstream (or general) classroom to provide them with specialist services, something *additional* or *different* to what is normally available (Florian 2008). In Ireland, this additional support often takes the form of learning support or resource teaching provided in one-on-one or small group settings *outside* the mainstream classroom (Shevlin, Kenny, and Loxley 2008). As such, one might query to what extent the Irish system is inclusive, if it continues to withdraw students for additional support. As will be discussed further in chapter 2, DHH children in this study were entitled to approximately three and a half hours of such resource teaching per week.

For others, the distinction between integration and inclusion is not simply about placement, but about ideology. At the heart of this ideological issue is whether or not the provision of special (i.e., separate) education is "part of the problem or part of the solution" (Florian 2008, 202) in providing for children with special educational needs. Can we claim to be inclusive, if we continue to withdraw children for specialist services? Can inclusive education truly meet the needs of all children in a way that is equitable and educationally appropriate? Are special schools never inclusive? These questions move beyond looking only at placement of students as an indication of whether or not they are included, highlighting Powers' assertion that "inclusion is an attitude not a place" (Powers 1996). Furthermore, these questions lead to dilemmas and tensions for education providers in how they meet the needs of students with special educational needs (Norwich 1993). Within inclusive settings, therefore, "schools attempt to provide for the personal, social, and learning needs of *all* their students" (Power and Hyde 2002, 302), and any specialist services required by the child are provided within the mainstream classroom and not outside it (Jackson Croyle 2003).

Building on this distinction and the dominant practice in Ireland at present, I refer throughout this book to the *integration*, or *mainstreaming*, of DHH children, rather than the *inclusion* of DHH children. Although the term *mainstreaming* is less common in international literature, Lindsay

(2007) notes it is still widely used in the United States, and I have observed it to be the prevalent term used among the Deaf community in Ireland, perhaps highlighting the influence of the United States system on that community.[2] As such, the term *mainstreaming* throughout this book refers to the placement of DHH students in regular or general classrooms in public schools. The terms *mainstreaming* and *integration* are (at least in the context of this book) synonymous.

Two types of mainstreaming are discussed in this book: individual/full mainstreaming and group mainstreaming. *Individual/full mainstreaming* refers to those students who are the only DHH student, or one of very few DHH students, within their school. Oliva (2004) refers to these students as "solitaires." *Group mainstreaming* refers to situations where there are a number of DHH students grouped together in a unit within a mainstream school. These units are sometimes referred to as *facilities for DHH children*, *special classes*, or *partially hearing units*. It is common practice to refer to these classes as *special classes* in Ireland, but the Deaf community in Ireland rejects the use of the term *special*. As such, the term does not feature in this text. In this book, they will be referred to simply as *units*. Schools catering specifically to DHH children are referred to as *schools for the deaf*, a phrase commonly used by parents, service providers, and the Deaf community in Ireland.

The Study

This book is based on empirical research gathered as part of my Ph.D. from the National Institute for Regional and Spatial Analysis and the Geography Department at Maynooth University, Ireland. Because so little had been written about deaf education in Ireland, I conducted an exploratory study to contribute to the country's national knowledge base of its

---

2. A number of Irish Deaf academics and community activists have lived for some time in the United States, in particular at Gallaudet University. Although hearing teachers in deaf education in Ireland commonly receive their specialist training in the United Kingdom (our government funds teachers taking postgraduate qualifications in deaf education in the United Kingdom), Deaf adults also commonly travel to the United States under the Fulbright Deaf Studies scheme, for example.

mainstreamed DHH students. With an inductive approach influenced by grounded theory (Strauss and Corbin 1994), I collected qualitative data, using an open narrative interview approach (Elliott 1995) 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 mainstreaming experience. The research was informed and guided by two overarching and interconnected questions. If mainstreaming was about including *all* children, why was it that, in Ireland at least, DHH children who signed were not usually in mainstream schools?[3] Furthermore, because it arose in response to a social model of disability, what did mainstreaming mean for a social model of Deafness? As a result, the research sought to examine the decision-making processes among parents in terms of the school placements they considered, the language(s) they used to communicate with their DHH child, and the relationships between these decisions. Subsequent thematic analysis of the interview transcripts revealed that decisions (and responses to those decisions) were often embedded within multiple layers of power relationships, which will be analyzed in depth in the coming chapters, adding to our understanding of mainstreaming beyond the academic consequences of this move.

The Research Participants

The data presented in this book are based on the stories of 25 DHH children, based on interviews conducted between 2007 and 2008. The stories were collected through interviews with a convenience sample of hearing parents and/or professionals working with the children, and some interviews were with the children themselves. Twenty interviews were carried out with parents (sometimes one parent in the household, sometimes both). Another 20 interviews involved a range of professionals, only two of them Deaf, including teachers in units for deaf children in mainstream schools, teachers in mainstream schools, resource teachers in mainstream schools, principals in mainstream schools, Special Needs

---

3. In the Irish legislative framework, the *Education for Persons with Special Educational Needs (EPSEN) Act* of 2004 cautions that children may not be included in public schools, if doing so is inconsistent with (1) their best interests or (2) the provision of education to their peers (Government of Ireland 2004).

Assistants (SNAs), and Irish Sign Language (ISL) tutors.[4] Eight DHH children, who were selected using purposive sampling, were interviewed in paired or group interviews.

The 25 children were diverse in terms of age, ability, rural–urban residences, nationality, linguistic background, and level of use of assistive technology. Some descriptive detail on the children is presented in table 1.1, although, owing to the small population of DHH children in Ireland, I am unable to offer detailed information on each child. Even with pseud-onyms, I could inadvertently identify children, given their nationality, age, and school placement. As a result, the individual data from the table is supplemented with data summarizing the characteristics of the group. Furthermore, although a child's level of deafness and use of assistive tech-nology does not summarize the complex and interconnecting variables that can influence his or her educational experience, this information is provided to give the reader some context for the participants.

At the time of the first round of interviews with parents and profes-sionals, the children were aged between 24 months and 16 years, with an average age of 8 years. Although the research was largely concerned with the years following identification and early schooling (i.e., when decisions on school placement were made), some older children were included in the study to capture the experiences of those who had pro-gressed through the full primary education system and transitioned to post-primary education.[5] Among the participants, 10 were attending a

---

4. Special Needs Assistants (SNAs) have a role similar to that of paraprofessionals in the United States. Importantly, SNAs are involved in the care needs of students only and do not engage in teaching activities. Also, distinct to the Irish context, they facilitate communication between the ISL-using children and other children and/or professionals. However, SNAs are not qualified sign language interpreters and may only have learned to sign subsequent to the enrolment of a DHH child in their school.

5. In Ireland, primary education begins at age four or five, although education is not compulsory until children are six years old. Pupils spend eight years in primary school with children completing their primary education at approximately 12 or 13 years of age. Post-primary schooling consists of a three-year junior cycle, culminating in state examinations called the Junior Certificate, and a two-year senior cycle culminating in the Leaving Certificate examinations. There is an optional "transition year" between junior and senior cycles. Schooling is compulsory until 16 years of age, but students completing their Leaving Certificate are usually 17 or 18 years old.

TABLE 1.1 *Individual Characteristics of the Children in This Study.*

Family	Child's pseudonym	Child's age at time of parent interview (in years)	Level of deafness and assistive technology used
01	Henry	5	Profound, CI
02	Chris	9	Severe-profound, HA
	Ellen	5	Profound, CI
03	Áine	14	Severe-profound, HA
04	Marie	10	Profound, CI
05	Elaine	3	Profound, CI
06	Daniel	16	Profound, CI
07	Michael	13	Profound, CI
08	Noel	7	Profound, CI
09	Mark	2	Profound, CI
10	Cormac	8	Severe-profound, HA
11	Jane	12	Profound, HA
12	Darren	8	Profound, HA
13	Abdul	8	Profound, HA
14	Albert	10	Profound, CI
	Grace	7	Profound, CI
15	Matthew	10	Moderate-severe, HA
16	Hazel	13	Profound, HA
17	Seán	8	Severe, HA
	Nuala	5	Profound, CI
18	Leanne	12	Moderate, HA
	Jessica	11	Profound, CI
19	Paul	7	Profound, CI
20	Conor	10	Profound, CI
	David	8	Profound, CI

Cochlear implant = CI; hearing aid = HA.

unit for DHH children in a mainstream school, 11 were in a full main-stream program, one was enrolled in a school for the deaf, one was in a special school for children with general learning disabilities, and two were of preschool age (one would later go to a school for the deaf and the other a mainstream school). In Ireland, approximately 76 percent of children are

in full mainstream placements, with another 2 percent enrolled in units attached to mainstream schools (National Council for Special Education 2011) and as such, children attending specialized placements are over-represented in this study. Fifteen of the children had cochlear implants, whereas 10 used hearing aids. In addition, four of the children were from families who had migrated since their birth to Ireland, and English was a second language in the household. Four children out of the 25 had received a diagnosis of an additional disability, and a number of others were undergoing assessment for general learning disabilities.

Despite their diversity, these children shared a number of common characteristics. All of them were from houses headed by two parents/guardians and, although no question was asked directly of socioeconomic status, most of the participants were from middle-class backgrounds (fully employed and living in private homes, with access to their own transportation). Participants' ability to finance private health care services varied and was discussed through the interviews. Interviews with the Deaf participants were carried out in ISL. The confidentiality of participants was protected by removing names and coding the interviews. Families were assured that they could withdraw their data at any stage during the study, but none chose to do so.

Conducting 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 hearing researcher with no personal experience of d/Deafness (none of my family are Deaf), I was anxious not to reproduce these oppressive experiences further through this research. As a result, critiques of the power relations operating within traditional research designs that work to oppress research subjects, particularly those from minority or "at-risk" communities, were 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, a vibrant debate occurred on the topic of whether or not nondisabled researchers had a role to play in the Disability Rights Movement (DRM). Authors like Branfield (1998) argued that the relationship between nondisabled people and the DRM was impossible, because, despite the empathy nondisabled people could have, their very status as nondisabled brought with it domination, oppression, and appropriation. This was in response to criticisms of the so-called "rape model" of research, whereby nondisabled researchers used disabled people as subjects to produce research that would advance their career but provided very little benefit to the disabled community. Shakespeare (2006) highlights that this rejection of nondisabled researchers was widespread at the beginning of the DRM due to the parasitic nature of previous research. However, he highlights that this does not jettison outright the role of nondisabled researchers, but rather emphasizes the need for a rigorous research agenda that rests in the hands of disabled people and an accountability to organizations run by disabled people. In particular, Shakespeare criticizes 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 "activist discourses" to adhere to "the dichotomy between nondisabled and disabled people which becomes coterminous with the dichotomy between oppressors and oppressed" (64). Highlighting that the social model was established by people with physical disabilities, she stresses that quite often, those with less-apparent disabilities are marginalized within the DRM. She includes herself in this group, as an ex-disabled person who occupies a liminal position within the movement. Furthermore, she is concerned that a worldview that demands that "lived experience of a given oppression is a necessary if not sufficient prerequisite for understanding that oppression and becoming part of the solution rather than part of the problem" falls into self-contradiction, where research about blind people could only be done by blind people, research about deaf people could only be done by deaf people, and so forth, with no group of people with a particular disability possessing the lived experience to understand another (ibid., 64).

The Deaf Studies discipline has also been susceptible to this form of dichotomous exclusion of hearing people working in the deaf education field (Broecker 2001), ever-cautious that those who are not DHH 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. I came to this research project as a doctoral student who did a small undergraduate study examining deaf education; I also received a Master's in Deaf Education at Gallaudet University. Although I had a good degree of competency in both American Sign Language (ASL) and ISL when beginning this doctoral study, I had not worked professionally with DHH people. My sign language skills were developed at evening classes (in the case of ISL) and during my postgraduate study (in the case of ASL). As such, although I could converse directly with members of the Deaf community to explain my background and the purposes of my research, I was still very much an "outsider" to the Deaf community when I embarked upon this study.

Hearing researchers can sometimes meet Deaf people who dismiss their work by using the sign HEARING-BENEFIT.[6] 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 (Kitchin and Hubbard 1999), but also the difficulties faced by hearing researchers committed to becoming meaningful advocates within the community. The perceived benefits received by hearing professionals in advancing their careers through research done "on," but not "with," the Deaf community can cause a great deal of tension between Deaf people and hearing professionals. Lane et al. (1996, 446) discuss the collision between hearing and deaf agendas and refer to the *troubled-persons industry*, borrowing a term from sociologist Gusfield to

---

6. Small capitals denote an English gloss of a sign language term.

describe professional services designed to "bestow benevolence on people defined as in need" (Gusfield, 1989, cited in Lane 1997, 156). Among these professionals, Lane includes researchers who "serve not only their clientele but also themselves" (ibid., 156).

Acknowledging therefore, the unavoidable nature of the power relations involved in research conducted by hearing people among the Deaf community, the research described in this book was guided by a post-structuralist/feminist epistemological desire to understand the processes that form and disseminate such power relations. This research aims to disempower the discourse/dualism of hearing-normal/deaf-abnormal, propagated especially through the education and health service systems, and is sensitive to the fact that many DHH 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, such as researchers, in positions of power. In light of the debates outlined above on the role of nondisabled and hearing researchers within the field therefore, this book keeps in mind the dangers of reproducing institutional power relations through the research process.

Theoretical Framework for the Study

Given the overall concern toward discourses and power both within an institutional setting (the education system) and the research process itself, it is perhaps unsurprising that the theoretical framework for this book derives from the work of Michel Foucault (1984, 1984b, 2001, 2002, 2002b, 2002c, 2007, 2012) as well as literatures on geographies of power (Allen 2003; Rose 2002; Sharp, Routledge, Philo, and Paddison 2000). This framework is used as a lens through which I examine the current system of deaf education.

Inspired by Foucault's genealogy works, and following from the work of McDonnell (2007), I also acknowledge that both contemporary *and* historical contextual factors, as they relate to the construction of "truth" and power, must be made explicit. Despite the fact that mainstreaming is a recent occurrence, providing contemporary context alone is not enough. As a result, the history of deaf education, both internationally and in

Ireland, must be addressed along with the origins of d/Deafness as both a medical and social construct.

Structure of This Book

The first section of this book (up to and including chapter 3) provides the background and context for the research. Chapter 2 introduces the international context of mainstreaming, the literature on mainstreaming of deaf education, and the system of deaf education in Ireland. Chapter 3 provides the theoretical backdrop for the three discussion chapters that follow, examining in particular the theorizing of power and resistance. In chapter 4, I look to the history of deaf education to argue how a medical model of deafness was established in the 19th century. Chapter 5 continues the discussion of power and how the medical discourse of deafness becomes hegemonic by looking at the contemporary system in Ireland. It examines the reproduction of this 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 power relations between a trio of individuals: experts, parents/teachers, and DHH children. In line with Allen (2003), it addresses the spatiality of power, especially how this is played out in the mainstream system where deinstitutionalization and the subsequent shift in the geographies of governance would suggest a change in how power operates.

Chapter 6 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 medical model of deafness. It analyzes the changing geographies of those resisting practices in the wake of mainstreaming, and how the decline in residential schools for the deaf has had an impact on resistance. Specifically, although resistance was traditionally in the hands of the Deaf community, passing from one generation of DHH children to the next in the residential school system, resistance must now emerge from the actions of hearing parents on behalf of their DHH children. The fracturing of traditional forms of resistance used by the Deaf community and the threat posed

by mainstreaming to the intergenerational transfer of the social model of Deafness are examined as causes of deep unrest within that community regarding the mainstreaming movement. Chapter 7 provides a conclusion and summary of the book as a whole.

Conclusion

This book examines how and why DHH children are mainstreamed. It is my hope that uncovering how medical and social models of d/Deafness operate in the current system will provide readers with opportunities for questioning and possibly resisting the systems they are embedded within, because, as Allen (2003) 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" (196).

Before embarking on this analysis, it is important to stress from the outset that what is under scrutiny here is a hegemonic medical model of deafness. This is not to say that those who work within the medical system are individually at fault for this, nor that they all subscribe exclusively to this model. Furthermore, it should *not* be interpreted as an argument that DHH children be denied access to medical services or to opportunities to acquire speech and be included in schools with their hearing peers. Advances in technology and changes in educational policy mean that now, more than ever before, DHH children have opportunities to acquire speech, remain with their families in their local communities, and integrate with hearing peers—I view this as a very positive development. However, this becomes problematic (and arguably damaging) when it is accompanied by a negative discourse of Deafness, sign language, and the Deaf community.