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A Postmodern Perspective on the Issue of Deafness as Culture Versus Pathology

By Mary T. Wohar Torres

Abstract

There is a growing controversy within the field of mental health and deafness over the understanding of deafness as a cultural identifier versus as a pathological condition. Meanwhile, the development of postmodern ways of thinking about therapy in general offers a constructive paradigm from which to discuss this issue. Accordingly, the author examines the meaning of deafness from a postmodern perspective as well as some implications of this view for therapy involving hearing therapists and deaf clients. She concludes that linguistic and cultural sensitivity on the part of the therapist is paramount in importance when the goal of therapy is to permit the freest possible exchange of ideas as well as the collaborative development of new meaning.

Introduction

When I entered Gallaudet University, the world's only liberal arts college for the deaf, in 1977 as a hearing student in the graduate counseling program, I was shocked to encounter the hostility of deaf undergraduate students who demanded that sign language be used on campus at all times. They expected the hearing graduate students to sign even with one another in the privacy of their dorm rooms when no deaf people were present! I was further startled when a deaf professor for one of my psychology classes forcefully undertook to purge his hearing students—myself included—from attitudes towards deaf people such as paternalism of which I was previously unaware. He implied that we could otherwise do more harm than good as helping professionals in the field of deafness and mental health.

I was puzzled by the realization that my help, and even my presence on campus, was not as welcome as I had thought it would be. I reconciled my experience of what I considered to be a form of reverse discrimination in terms of the oppressed members of a minority group themselves becoming oppressors upon finding themselves for the first time in a majority position (Freire, 1982). At the time, I naively lacked the historical perspective to recognize that there was indeed a revolution afoot in the heart of the deaf world. This revolution culminated in 1988 in a protest by students and alumni at Gallaudet University which stunned the hearing world and resulted in the appointment of the first deaf president to that institution. Professor Allen Sussman spoke at one of the protest rallies, and defined the event as "historical...the first deaf civil rights activity" (Shapiro, 1993, pp. 208-209). This trend is largely expressed by a growing appreciation for and interest in American Sign Language as a viable linguistic system which identifies and unites Deaf people as a legitimate ethno-cultural group.

Defining the Controversy

This same process creates and increases the unique challenges of providing psychotherapeutic and psychodiagnostic services to deaf persons by the majority of mental health service providers to deaf clients who are hearing persons with minimal competence in sign language. The predictions Trybus made in 1980 are quickly coming true:

What we can expect to see ahead, then, is increasing criticism and rejection of mental health services offered to deaf clients by hearing practitioners so removed from the Deaf ethno-cultural community as to be

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considered simply foreigners. These practitioners, in turn, can be expected to respond with resentment, confusion, and some bitterness, when their attempts to be of service are rebuffed or criticized by their actual or potential clients. (p. 215)

This presumed negative response on the part of mental health providers seems to refer to the tendency which has been dominant for decades within the fields of psychiatry, psychology and psychotherapy, i.e. to "emphasize psychopathology in its conceptualizing and treatment of clients" (Guterman, 1994, p.226). These fields have been generally and traditionally "informed by empiricist, positivist, or rationalist epistemologies...that contend that it is possible to attain or approximate objective knowledge of reality" (Guterman, 1994, p.227). Thus, deafness is assigned its place on Axis III of the Diagnostic and Statistical Manual of Mental Disorders (4th ed., rev., 1994) used within these fields to ascribe labels to individuals in order to signify particular pathology and classes of symptoms exhibited.

As Keeney (1979) explained, such psychiatric nomenclature "is inseparable from the underlying assumption that an individual is the receptor of lineal causal effects and hence the site of pathology" (p.118).

The logical outcome of this traditionally scientific and medical perspective is to view deafness as a disability—a deficit in the ability to hear. Consequently, deafness has been widely regarded as a handicap to normal development in the areas of language, personality and social adaptation, as well as being an impediment to academic and vocational achievement. Statements—such as the often quoted one made by I. King Jordan, first deaf president of Gallaudet University—that "Deaf people can do everything but hear" make little sense. The phenomenon of persons with a sensory handicap attempting to describe themselves as a cultural group appears to be blunt and pathological denial. Treatment indications might well include confronting this denial, and helping deaf clients work through unresolved grief issues over the loss of their hearing—as suggested by Mindel and Vernon (1971), noted psychiatrist and psychologist, respectively, in the deafness field. (I recall how eagerly I read their work as an impressionable undergraduate student, and how I regarded it as a training manual and standard for my own future work in the field.)

This same pathological view of deafness permeates the heated debate which has been waged in the field of deaf education since the 1800s when Alexander Graham Bell, widely recognized champion and benefactor of deaf people, suggested that deafness was "a sickness, something that needed to be cured" (Shapiro, 1993, p. 90). His influence led to the repression of sign language in deaf schools as well as the spread of oralism, a method of education which attempted to teach the deaf to speak and lip-read in order to use the language of the dominant culture. Thus;

Deaf students were molded in the image of the hearing world, and their inability to speak was seen as a shortcoming in need of correction. American Sign Language (ASL) was dismissed as a crude slang. (Shapiro, 1993, p. 92)

This suppression of sign language continued until the 1970s when academic linguists began to recognize and promote ASL as a legitimate language with its own complex and nuanced grammatical structure and syntax (Bellugi, 1980).

Deaf people began to reclaim ASL as their natural language, and slowly gathered the momentum which culminated in the Gallaudet uprising. Oliver Sacks (1990) sums up the recent history of this liberating movement:

Deaf depreciation, deaf deference, deaf passivity, and even deaf shame were all too common before the early 1970s...the deaf movement since 1960: there were many other factors...the mood of the sixties, with its special feeling for the poor, the disabled, the minorities—the civil rights movement, the political activism, the varied "pride" and "liberation" movements; all this was afoot at the same times that Sign was slowly, and against much resistance, being legitimated scientifically, and while the deaf were slowly collecting a sense of self-esteem and hope, and fighting against the negative images and feelings that had dogged them for a century...an increasing sense that peoples could be profoundly different, yet all be valuable and equal to one another...a movement from the medical or pathological view to an anthropological, sociological, or ethnic view.

Once this shift occurred, deaf people such as the students at Gallaudet, concluded that they should "make their own world" (Shapiro, 1993, p. 99). They became increasingly distrustful of the involvement of hearing people in their lives. As Padden and Humphries (1988) related, there is a theme of warning in many Deaf stories against the threats to "the very existence of a sign language and of their way of life in the face of tremendous pressure for speech and for living in terms of
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others’ world” (p.38). They apparently and understandably fear that the hearing world, including those who profess to be their benefactors, may again try to overpower their identity and use of Sign.

This brings us to a seeming impasse between modern deaf consumers and Modernist (i.e. operating from a traditional, scientific, medical model) mental health service providers. The traditional paradigm for practitioners requires that deafness be viewed and treated as pathology. But deaf consumers are beginning to vehemently reject the dominant societal view of deafness as a pathology. Subsequently, the trend is towards rejecting the help of hearing mental health therapists who have been socialized into and adhere to pathologizing medical models in their approaches to counseling. The options available to either side on this controversy, however, appear to be limited and unsatisfactory. There is a paucity of native ASL users among the ranks of practicing mental health providers at this time. Yet, there is a place and need for the services of psychiatry, psychology and psychotherapy to the deaf population. Can the consumers and service providers of today find a way to resolve their differences and continue to work together? Is there a way across the impasse?

Postmodern Thinking about Therapy

Interestingly—and probably not coincidentally, a movement from the medical or pathological view to an anthropological, sociological, or ethnic view was simultaneously occurring within the field of family therapy. Referred to by Hoffman (1990) as Postmodern thinking, this trend in the therapy field "amounts to a proposal to replace objectivist ideals with a broad tradition of ongoing criticism in which all projections of the human mind are concerned." Bateson ushered in this postmodern era with his pioneering work in exploring the nature of mind (1972, 1979) which indicated that objective realities cannot actually be known. During this new era, a general epistemological framework known as constructivism developed. Constructivism, as defined by Watzlawick (1984) in a review by Guterman (1994), "contends that knowledge is not a reflection of objective reality but, rather, is the result of our own (i.e., subjective) cognitive processes" (p.229). The epistemological doctrine of social constructionism has since emerged from the intellectual background of constructivism.

Social constructionism was developed and influenced largely in the United States in various fields. (Guterman, 1994) Unlike constructivism, which posits that human knowledge is skull-bound (Hoffman, 1990), social constructionism "locates ideas in the domain of language between persons" (Guterman, 1994, p.230). Hoffman (1990) stated that "as we move through the world, we build up our ideas about it in conversation with other people" (p.3). She further explained that social construction theory "sees the development of knowledge as a social phenomenon and holds that perception can only evolve within a cradle of communication" (p.3). Hence, this epistemological doctrine holds promise as a bridge for hearing therapists to understanding and respecting the meaning which Deaf clients assign to their deafness.

Anderson and Goolishian (1988) made a giant step forward possible by describing any human system, including the therapeutic system, as a "linguistic or communicative system [in which] meaning and understanding are socially and intersubjectively constructed" (p.372). Among themselves, Deaf people down through history and particularly so in recent years, have assigned a different meaning to their deafness than the pathological view advanced by the medical model wherein society sees deafness as a pathology. The world of deaf people, said deaf authors Padden and Humphries (1988), revolves around a "different center" (p. 42). For Deaf people, "the greatest deviation is HEARING" (p. 41). Deaf people discussing their deafness tend not to focus on pathology or deafness. Instead, they "use terms deeply related to their language, their past, and their community" (p.44). Since the Gallaudet revolt, Deaf people have more and more collectively and cooperatively decided to be "proud to be deaf" (Shapiro, 1993, p.85), and to show their pride by celebrating their differentness while striving to preserve their "rich deaf identity" (Shapiro, 1993, p.99).

Once this new consciousness was established, the rediscovery of American Sign Language "sparked a deaf cultural renaissance" (Shapiro, 1993, p.103), which Sacks (1990) described:

There arose Sign poetry, Sign wit, Sign song, Sign dance--unique Sign arts that could not be translated into speech. A bardic tradition arose, or re-arose among the deaf, with Sign bards, Sign orators, Sign storytellers, Sign narrators, who served to transmit and disseminate the history and culture of the deaf, and, in so doing, raise the new cultural consciousness yet higher. (p. 149)

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The legitimization of ASL by the linguistic field began to impact the view of hearing society at large, and led to:

...an increase in portrayals of deaf people in every medium, from documentaries to plays and novels—a portrayal increasingly sympathetic and imaginative. Changing social attitudes, and changing self-image [led to the result that]...Deaf people, and those who studied them, started to look back into the past...to discover (or create) a deaf history, a deaf mythology, a deaf heritage. (Sacks, 1990, p. 152 and p. 153)

This different view of deafness as culture has not yet widely permeated the mental health field, but postmodern thinking about therapy has certainly laid the groundwork for more and more practitioners to both acknowledge and participate in it without necessarily compromising the integrity of their own views. I refer to the Guterman (1994) article for an excellent articulation of such an approach which affords therapists with a systemic foundation from which to borrow from other schools while retaining the integrity of a social constructionist orientation. I personally find this approach to be highly appealing on the grounds that it offers maximum maneuverability for incorporating the best that both scientific and linguistic models have to offer.

Clinical Implications for Hearing Therapists Working with Deaf Clients

Hinkle (1994) proposed that the "ecosystemic paradigm is a turning point in the mental health field" (p.33) because it offers therapists the possibility of being helpful to clients without imposing their own worldviews. He reminded us that people—including therapists—are socialized into the worldview in which they are born. When we consider the therapeutic relationship, it is obvious that two worldviews are represented—that of the therapist, and that of the client. The worldview of a hearing therapist will obviously be different from that of a deaf client. But though an awareness of this difference becomes prerequisite for informed dialogue, it no longer needs to be problematic.

Hinkle (1994) echoed the shift in epistemology which was encouraged in the early days of the postmodern era by Bateson (1979) when he declared that "it is correct (and a great improvement) to begin to think of the two parties to the interaction as two eyes, each giving a monocular view of what goes on, and, together, giving a binocular view in depth" (p.133). As Amatea and Sherrard (1994) suggested, "By synthesizing the double descriptions gained from the two places to sit, clinicians pursue the bonus of depth, the vision of differences that make a difference, the construction of patterns that connect." (p.4). When proceeding along these lines, the existence of two different worldviews can be regarded as a resource rather than a source of conflict.

Furthermore, from a social constructionist viewpoint, it becomes no longer necessary, useful, or even logical to debate whose view, i.e. that of the hearing therapist or that of the deaf client, is objectively true. Watzlawick, Weakland, and Fisch (1974) contended that "real is what a sufficiently large number of people have agreed to call real—except that this fact is usually forgotten" (p.97). Social constructionists thus presuppose that clients and clinicians "share a reciprocal role in creating clinical 'realities' because...so-called 'reality' exists in the domain of intersubjective communication" (Guterman, 1994, p.231). Therapy can thus be defined as "a linguistic event that takes place in what we call a therapeutic conversation" (Anderson & Goolishian, 1988, p.372). This conversation is a "mutual search and exploration through dialogue, a two-way exchange, a crisscrossing of ideas in which new meanings are continually evolving toward the 'dis-solving' of problems" (Anderson & Goolishian, 1988, p.372).

The therapist's role in this light is that of a "master conversational artist—an architect of dialogue—whose expertise is in creating a space for and facilitating a dialogical conversation [as a] participant-observer and a participant-manager" (Anderson & Goolishian, 1988, p.372). Therapy can further be likened to "a process of listening to clients confirm therapists’ expectations as, in turn, therapists confirm theirs" (Anderson & Goolishian, 1988, p.373). This "process view" suggests that "we may use language in a coevolutionary way in which new order of difference, relationship, and context may emerge" (Penn, 1982, p.268). It also suggests that the expectations of both parties to the conversation of therapy play a critical role in how the dialogue will progress and unfold. If a hearing therapist expects to find limits and problems resultant from the client’s deafness, the therapist is likely to arrange the data from the conversation, i.e. diagnose in accordance with this form of epistemology. The therapist's way of diagnosing is then likely to affect the client, as therapist and client act on one another. (Keeney, 1979) Deaf consumers are becoming increasingly reluctant, under these circumstances, to subject themselves "to struggle against the low expectations of the hearing world" (Shapiro, 1993, p.75).
They understandably prefer to engage in therapeutic conversation with someone whom they believe will collaborate with them rather than impose a story which they themselves no longer see as fitting.

In their interactions with one another through participation in deaf culture, Deaf people have already evolved and agreed to assign different meaning to their deafness. They have done what other individuals almost always seek to do, according to Salebey (1994), which is to organize their world in a way that is more predictable, satisfying, resonant, interesting..." (p.356). They have built themselves into today's world by creating new meaning about "who they think they are, what they think they are doing, and where they think they are going" (Salebey, 1994, p.351). They are telling themselves new stories about what it means to be deaf. As I. King Jordan told the student body when he accepted the Gallaudet presidency, "We can no longer accept limits on what we can achieve" (Shapiro, 1993, p. 83). These Deaf people no longer believe that the old story told by the hearing world about deafness as pathology is true or inherently superior. Nor are they particularly interested in hearing it any longer.

Fortunately, the practical implications of taking a social constructionist approach in therapy with Deaf clients are promising. Pragmatically, this paradigm fits with the current movement in deafness towards self-determination and empowerment. Because it is much more compatible with cultural and political trends in deafness today, it is more likely to make therapy a collaborative and productive endeavor rather than an arena for impasse. As I accept Hoffman's invitation (1990) to imagine what a new and different story of therapy might be, I envision what postmodern therapy might be with persons who are Deaf. Hopefully, the focus will be on "together finding or producing narratives that promote a difference in the way people experience and act in their situations [and work with individuals to] articulate those meanings, those stories, those possible narratives that elevate spirit and promote action" (Salebey, 1994, p. 357). The focus will be on co-creating positive visions of the future, in order to support Deaf people in their efforts "to see their current predicaments as phases in a continuing narrative, where hardships are steps on the path to a better tomorrow" (Ferman & Abola, 1992, p. 93). There is an inevitable connection between what people do and what they think they can do and the interpretive frameworks available to them. So stories of hope, survival and accomplishment can be instruments of empowerment. Using language which emphasizes people's resources rather than their failings (Ferman & Abola, 1993) can be self-fulfilling.

In the language of the postmodern era, all linguistic representations of reality created within the context of interpersonal communication are, in effect, stories. "Stories," asserted Becvar and Becvar (1994), "constitute our experienced reality" (p.24). Realities are filtered through beliefs and values, and are mediated by language. (Becvar and Becvar, 1994). No story is inherently superior. There are no distorted perceptions. Each story represents a unique, contextual truth. A story is true if it fits, i.e. "if it helps to complete the pattern from which emerges meaning." (Becvar and Becvar, 1994, pp. 24-25) The guideline is utility:

"believing is seeing and seeing is creating. We must therefore ask ourselves, what other kind of world can we believe, see, and thus create?...The awareness that the world in which we experience ourselves is a story and that many stories about ourselves and the world are possible provides us with hope, tolerance, responsibility, uncertainty, and total freedom. (Becvar & Becvar, 1994, p.32)

Hearing therapists practicing from a postmodern perspective will attempt to come into the system of their Deaf clients without pathological definitions or set ideas about what should or should not change. They will keep in mind that each person tells a unique story, and will refrain from stereotyping Deaf clients. They will realize that each Deaf client has a unique story to tell about the etiology, age of onset, degree and meaning of their deafness as well as their family experiences, language and education. Such therapists will not make egregious errors such as assuming that all Deaf people can lipread or know Braille. They will not seek to discover problems, and so will not assume that a profoundly deaf person has more negative feelings about communicating with a hearing therapist than does a hard of hearing individual.

**Linguistic and Cultural Sensitivity**

Because social constructionist therapists recognize that the "predominant linguistic form will have an important effect on the nature and direction of the evolving conversation" (Tomm, 1988, p.2), they will carefully consider the language used to hold the therapeutic conversation. When therapy is conceived of as dialogue, the desirability of maximum facility in
the formal language used to conduct such a dialogue seems obvious. Linguistic and cultural sensitivity take on paramount importance.

Consider the analogy of a Russian-speaking therapist engaging in therapeutic conversation with an English-speaking client. Aside from the impossibility of comprehensible verbal communication, even non-verbal communications, e.g. the amount of physical distance between the therapist’s and client’s chair, use of eye contact, physical touch, and so forth could be misinterpreted much more easily in counter-therapeutic ways than if both therapist and client were native Russians speaking Russian together. Then, consider the possibility of the Russian-speaking therapist doing therapy with the same English-speaking client through the use of an interpreter. At the very least, the process of dialogue would be slower, and the immediacy and recursiveness of non-verbal feedback communication would be less timely. Because American Sign Language is "an independent language with its own grammatical rules" (Bellugi, 1980, p.72), there are similar implications. If the Deaf client is a fluent signer, equal fluency on the part of the therapist would permit for the most immediate and uninhibited exchange of ideas and evolution of new meaning through dialogue. Mutually fluent signing would be most conducive to "a free intercourse of minds, a free flow of information" (Sacks, 1990, p.31). Signing, Sacks further explained, is: "irreducibly, the voice of the signer—a voice given a special force, because it utters itself, so immediately, with the body. One can have or imagine disembodied speech, but one cannot have disembodied Sign. The body and soul of the signer, his

unique human identity, are continually expressed in the act of signing" (p.122)

This poignantly alludes to something of what may be lost in therapeutic interaction via an interpreter, and even more so when communication is attempted through writing alone. If therapists cannot sign for themselves, they will need to be aware of these drawbacks, and strive to work as effectively as possible with an interpreter.

On the other hand, a high level of signing proficiency offers the possibility of finding and incorporating linguistically sensitive interventions such as those described by Freedman (1994). The primary focus from a postmodern perspective will be on working with the client to "encourage and give free reign [to their] hopes, aspirations, possibilities, and immanent meanings and actions" (Salebey, 1994, p. 355). Therefore, therapists will strive to convey accurately their intent and ability to do the above, and will ultimately respect the choice of individual clients about their willingness to risk exposing their lived to a particular therapist's influence. In managed care situations, for example, therapists will not use their control of resources to force Deaf clients to accept therapy with them if the linguistic fit is unsatisfactory to the client. They will respect the right of clients to choose to advocate for alternatives from their insurance providers. They will equally respect the client's right to choose to accept what is available, and will not look for problems.

Closing Remarks

When hearing therapists undertake to engage in therapeutic conversations with Deaf clients, they make a commitment to be helpful. They can do this in respectful and culturally sensitive ways. If a particular Deaf client has assigned a meaning to all hearing persons as oppressors, this will affect the client's perception of the hearing therapist's epistemology and will influence the way in which the client's story gets told in therapy. But if therapists can dialogue with such clients in a recursive way, then it seems possible that the therapist will listen to the story, and then collaborate with the person to invent other stories or other meanings for the stories that are told (Hoffman, 1990)—including the stories the Deaf clients were telling themselves about the therapist at the onset of therapy.

Therapists will "hopefully create an emancipatory dialogue rather than reinforce the oppressive or monolithic one that so often comes in the door" (Hoffman, 1990, p.11). Therapists can do this by helping Deaf clients recognize the "awareness that the world in which we experience ourselves is a story and that many stories about ourselves and the world are possible" (Becvar & Becvar, 1994, p.32). Postmodern thinking permits therapists the option to respect without having to refute the new meaning Deaf people have assigned to their deafness. It has profoundly impacted the way I think about my own therapeutic work with persons who are Deaf. After seventeen years of being puzzled about some of the things Deaf people have been doing and saying, it has given me new lenses with which to see and better understand. It has deepened my appreciation for the importance of linguistic and cultural sensitivity. Such an approach applied to therapy with Deaf persons can, I believe, be helpful and will, I hope, be welcome.
References


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