Models of Deafness: Cochlear Implants in the Australian Daily Press

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This article examined a database of Australian daily newspapers on the terms cochlear implant and deaf children to investigate how journalists and columnists report competing models of deafness: as either “medical” (deafness is a condition to be cured) or “sociocultural” (deafness provides a way of life to be lived). The results from the cochlear implant search favored a medical model, but the results from the deaf children search were more balanced, with a slight preponderance of articles favoring the sociocultural model. A number of representative quotes from articles in each model are provided and discussion entered into as to the possible effects of the articles on public reactions to deafness and especially hearing parental responses to the birth of a deaf child and the life choices that this event presents them.

In recent years, views of disability have divided into two (frequently opposed) categories: the so-called medical disability and sociocultural models.

Because of the prestige of “scientific medicine,” the medical model has dominated professional, media, and lay views until quite recently and, to a large extent, still does. Thus, in this model, deafness is seen as a condition that needs to be “cured” for the benefit of the individual and society: “The (deaf community’s) perception is that there’s nothing wrong . . . Our perception is, there is something that needs to be fixed” (Koch, 2001); “What do nasal decongestants, flu treatments and bionic ears have in common? Being remedies for unpleasant ailments” (Caruana, 1997, p. 36); and deafness is a “curable disease” (Miranda, 2003). Hearing aids, education (preferably in regular settings), and (lately) cochlear implants are invoked to provide this cure.

Power (2003a, 2003b) investigated “images” of deafness in the daily press reflected in reports and discussion about genetic screening to “discard” possibly deaf embryos and the (successful) “selection” for deafness by artificial insemination from a hereditarily Deaf man for a Deaf lesbian couple who wished to raise a Deaf child. Power found that reports and commentary on these topics favored the medical model that calls for the “normalization” of deaf people and opposed the sociocultural one of deafness as a way of life. This article extends this research into media representations of deafness by focusing on media reports on cochlear implants.

The Cochlear Implant

Just over 200 years ago, Alessandro Volta connected a battery to metal rods inserted in his ears and reported a very unpleasant sensation of sound. Peripheral stimulation apparently could provide some semblance of sound. Desultory work on electrical stimulation of the senses continued throughout the 19th century with no real thought of applied use, and modern work that led to the first usable implant that allowed discrimination of some sounds and even words was reported in 1957. “Single-channel” devices with some limited benefits appeared in the early 1970s, and the current multichannel devices appeared in the 1980s.
and began to be fitted to children in the mid-1980s (Spencer & Marschark, 2003).

A cochlear implant consists of a set of electrodes (22 in the most widely used device) that are inserted into the cochlea and connected through the skin to a processor that takes in speech and environmental sounds and reproduces the pattern of these sounds in minute electrical currents that simulate the external sounds and stimulate receptors in the cochlea, which transmit the impulses to the brain’s auditory areas so that a sensation of sound is obtained by the wearer. With intensive and lengthy auditory therapy, many deaf children have obtained noticeable benefit from their implant and have developed relatively normal language and speech and have been able to be placed in regular classrooms. However, it has been noted that a significant number of implanted children do not make as good progress as others and still require special education as deaf children and use some kind of signing for education and communication (Hyde & Power, 2004; Spencer & Marschark, 2003).

Children as young as a few months are now routinely fitted with cochlear implants, and with the increasing prevalence of universal newborn auditory screening, fitting at such ages is likely to increase in frequency. Fitting of prelingually deaf infants is what has led to controversy in the professional literature and the popular press. Proponents of the implant point to its successes and the normalization it provides for many children. They claim that the younger the child is fitted, the more successful the outcome is likely to be in terms of language, speech, and normalization (i.e., making the child as “hearing-like” as possible).

Models of Deafness

The medical model may well be called a hearing world view of congenital deafness. Most hearing people do not know any signing Deaf people and find it very difficult to comprehend or accept Deaf people’s view of themselves as “normal, just not able to hear.” They see deafness as an inability to communicate via speech and listening and in the usual metaphorical terms of “walls/prisons of silence” and the like. This is particularly true and traumatic for hearing parents of newly diagnosed deaf infants who grieve for the hearing infant they expected and are very susceptible to the promises held out by cochlear implant programs that they can normalize their child. Given the structure of early diagnosis and intervention programs in developed countries, they are rarely given the opportunity to explore the sociocultural view of deafness and so mostly willingly enter cochlear implant programs. For some children the promise of the implant is achieved, but for a significant number it is not, with consequent adjustments to lifestyles that can be difficult and cause delays in appropriate development for the deaf child (Hyde & Power, 2004).

Contrasted with the medical model is the sociocultural model, sometimes called a constructionist model because its proponents believe that all people construct their lives through interaction with the individuals and institutions of the culture in which they live: education, religion, peer group, vocational affiliation, social class, and so on, and, especially, our families (Gregory & Hartley, 1991; Power, 1997). The values, beliefs, and behaviors of each one of us are the outcomes of a host of influences that have impinged upon us and continue throughout our lives to shape the person that we are. This is quite distinct from having a medical condition that inheres in one.

The influences mentioned above are “outside” us, and they change and change us as we go through our lives. Some shaping influences cannot be changed. If one is born with a significant hearing loss, one is accompanied by deafness for life, and because one’s interactions with family, school, church, recreation, and work are inevitably shaped by the presence of one’s deafness, the person one constructs for oneself is shaped by the outcome of these interactions between self, societal institutions, and individuals: one becomes a “Deaf” individual.

Deaf people are a special example of the process and outcome of this construction of a life. It has become commonplace to talk about “the social construction of deafness” or “defining deafness socially” (as distinct from medically or audiologically; Gregory & Miles, 1991; Higgins & Nash, 1987). Deaf people have come to see themselves as a linguistic and cultural minority community rather than a “disability group.” This stance creates some tensions in the Deaf community about attitudes to obtaining services funding as regards, for example, government support for interpreting and relay services, which are often funded
under “disability” provisions rather than more “general service” ones.

A major source of controversy in the press and professional literature reflecting models of deafness has been the discussion of the potential for normalizing deaf lives personally, socially, and educationally by the fitting of cochlear implants (the so-called bionic ears). As will be seen below, there appear in the press stories of “miracles” of hearing and normalization from the use of a cochlear implant, oral education, and regular school placement. On the other hand, representatives of the Deaf community point to the ability of Deaf people to lead “normal” family, social, and work lives via sign language, writing, and (more often than is commonly supposed) speech (Hyde & Power, 1992) in both the Deaf and hearing communities. They therefore criticize much of the publicity surrounding cochlear implants as presenting a demeaning and inaccurate image of deafness. Typical is this statement from the Australian Association of the Deaf (AAD), which states that Deaf people do not see deafness as a condition that needs to be cured, “AAD’s views on cochlear implant should be seen in the context of the socio-cultural perspective on Deaf people’s lives.” According to the author cochlear implant advocates see deafness under a medical model of deafness and their publicity about cures and normalization “demeans Deaf people, belittles their culture and language, and makes no acknowledgment for the diversity of lives Deaf people lead, or their many achievements” (Lloyd, 2001, pp. 3, 7).

However, some softening of the stance of the Deaf community seems evident in some recent statements on cochlear implants.

Bahan, who is a well-known Deaf writer, activist, and father of two deaf children, wrote,

Conflicting perceptions about implants . . . have put the deaf community and the medical community on an apparent collision course for many years, but . . . this appearance may be the result of misconceptions about implants. When implants are seen as capable of changing deaf people into hearing people, members of the deaf community naturally see them as threats to their cultural identities. When viewed as devices that can help make the hearing world more accessible to deaf people . . . implants appear more like hearing aids, devices which deaf Americans, by and large, have come to accept. . . . If deaf children with implants are allowed to use sign language and maintain contact with other deaf people, then implants may be seen simply as helping them enlarge their scope of awareness without destroying their identities as deaf people. (Bahan in Johnson, 2000, p. 7)

Similarly, the change to the statement on cochlear implants on the (American) National Association of the Deaf (NAD) Web site (2000) expresses concern about “inflammatory statements” about Deaf people by some implant advocates and the medical profession. The NAD believes that the medical profession continues to “view deafness essentially as a disability and an abnormality and to believe that deaf . . . individuals need to be ‘fixed’ by cochlear implants” because of the “perceived burdens associated with being deaf” (NAD, 2000, p. 2). “. . . Cochlear implants, while not a cure for deafness, are now seen within a context of recognizing all technological advancements with the potential to foster, enhance, and improve the quality of life of all deaf . . . persons” (NAD, 2000, p. 1).

This is a far cry from NAD’s (1993) earlier position: The NAD DEPLORES the decision of the Food and Drug Administration [to approve implantation of children from two to seventeen years] which was UNsound scientifically, procedurally, and ethically. . . . The FDA erred in FAILING to obtain formal input from organizations of deaf Americans and from deaf leaders and scholars KNOWLEDGEABLE about the acquisition and use of sign communication and English in deaf children, and the social organization and culture of the American Deaf Community. . . . Otologists, speech and hearing scientists, manufacturers, parents, and members of the FDA staff were all consulted formally by the FDA in arriving at its decision. FDA’s FAILURE to consult deaf spokespersons represents, if an oversight, GROSS IGNORANCE concerning growing up in deaf America, or, if willful, an offensive against fundamental American values of individual liberties, cultural diversity and consumer rights. (capitals in original, no longer available from

NAD (2000) still pointed out the need for parents to be fully informed of all the possibilities of a “Deaf life” so that parents of newly diagnosed deaf children can make decisions “that incorporate far more than just the medical-surgical (and) involve language preferences and usage, educational training and placement opportunities, psychological and social development, and the use of technological devices and aids” (p. 3). I will demonstrate later that this position is not frequently reflected in daily press discussions of the topic.

In order to provide information on commonly presented models of deafness, this paper continues with an examination of popular press representations of deafness (Power, 2003a, 2003b)—in this case, in the presentation of cochlear implants and their impact on the lives of deaf children and their families.

Method

This research surveys Australian daily newspapers in major cities and uses the presentation of child cochlear implantation to draw conclusions about the representation of deafness in these sources. A database of newspapers (Factiva) was searched for the term cochlear implant for all Australian state capital daily newspapers and the National capital daily (a mixture of broadsheets and tabloids). The time span of the database was 1986–2003. An analysis of the articles found was conducted to determine the substance of the model of deafness of the content of these articles. In case of imbalance of opinions from the cochlear implant search and to provide a comparison with the cochlear implant data, a search was also done on the same database and at the same time period for the term deaf children, which was considered more neutral in approach.

Results

Cochlear Implants

The search described above on the Australian daily press database provided 357 “hits” for the term cochlear implant. Of these, 65 articles discussed the price of shares or commented on the status of the Australian company (Cochlear, Ltd.) that markets the world’s most commonly used implant (the Nucleus), 14 commented on the American Federal Drug Administration’s temporary ban on implants because of a suspected danger of meningitis and the ban’s non-applicability to the Australian device, and 13 were stories about the inventor of the device, Australian Professor Graeme Clark. A number of articles were on other topics related to deafness, such as the benefits of neonatal hearing screening and the possible dangers to implant wearers of mobile phone towers (later on reported to be not so), some were on other topics related only tangentially, and a large number proved to have little relevance to the topic under consideration.

This left 53 articles directly related to cochlear implants in children and 14 in adults. Generally speaking, the articles on adult implantation were noncontroversial and did not particularly “take sides” on the issue of models of deafness, although occasional references to “prisons of silence” and like phrases did appear. It is in the articles about cochlear implantation of children, especially at very young ages, that debate occurs, which throws light on the models of deafness the writers and those quoted (mostly parents, doctors, or teachers) have adopted. Only the articles on child implantation will be pursued in this paper.

A succinct representation of attitudes found in the selected articles can be found in their headlines, a number of which are presented below:

1. Listen, This Is a Miracle of Life
2. Prison of Silence Has Ended for 149 Youngsters
3. Samantha Emerges From World of Silence
4. Reward for a Miracle
5. Hears the Good News
6. Hugh Tunes in to a New Life
7. Toddler Lends an Ear to Life

The largely medical model “magic technological cure” oriented view of childhood deafness in these headlines is confirmed by examination of the text of the articles. Parents spoke of their “sole focus” being to get their child “to speak just like you or I” (Williams, 2003, p. 3). Another said the result of the implant was, “the best Christmas present anybody could have” (Chapman, 2003, p. 3). A reporter
described one mother’s reaction to the diagnosis of deafness as “devastating news. ‘I imagined a terrible lonely life ahead for her’” (“Devlin,” 2003, p. 33). Another spoke of “the best possible gift—a normal life” for her son as the result of an implant (David, 2003, p. 1). One mother spoke of her daughter being selected as a member of the Australian Youth Choir following her implant (“Samantha,” 1999, p. 3).

Statements from a leading surgeon and an educator in an early intervention program again provide the views of many professionals in the area.

Being born deaf should no longer be seen as a serious disability because of the “revolutionary” impact of the cochlear implant, said Professor Bill Gibson on the eve of implanting the “bionic ear” in the 150th child in NSW. “I seriously believe that if a child has no other problems, if a child is born deaf, provided we give them hearing at an early age, then deafness need no longer be a serious handicap,” he said yesterday. (Lamont, 1995, p. 7)

Profoundly deaf babies now have the option to grow up and be part of the listening and speaking world. Thanks to clever technology and therapy, babies diagnosed with hearing difficulties are able to learn their language as well as hearing children. … “It is absolutely possible for these children to learn and have language which means they can go to a regular school, move on to university and take their part in the community.” (Minogue, 1997, p. 36)

The use of terms such as “no longer … a serious disability” and “revolutionary … cochlear implant” by a leading surgeon clearly presents the medical model of deafness to be cured by the miracle of technology. Similarly, “be part of the hearing world,” “go to a regular school, move on to university and take their part in the community” reflects a need to make deaf children as hearing-like as possible as the only way to have a viable life as a deaf person by implying that only implanted and hence normalized deaf children can succeed in life.

Of the articles that were hits for cochlear implant, not all presented only the medical model side of the debate. Some, even when the general thrust of their position favored the medical model, did make some concessions to the sociocultural one. The following quote sums up the position that parents whose children are newly diagnosed as deaf are placed in:

The question of education is not about speaking or signing. It’s about how being deaf is seen and valued. … Parents … often receive information without being aware of the politics and zealous biases involved. Probably still in shock over the deafness diagnosis, they have to choose from a range of teaching methods, ranging from oralism (lip reading, speaking, hearing aids) to various sign languages and all the combinations and permutations in between. They may even be asked to decide if their child will become part of a culture and community to which they, the hearing parents, don’t belong. (Freeman, 1995, p. 11)

The statements from Clark in the quote below, while “welcoming … a more rational, considered debate,” still give the impression that implantation and a hearing-like way of life are to be preferred over a Deaf one.

Even the inventor of the Australian implant (Professor Graeme Clark) acknowledges that some of the pressure has gone out of the argument. Deaf people can communicate efficiently through sign language, facial expression and body language, and do not see themselves as handicapped. Some have regarded the bionic ear as a technological intrusion that threatens the culture of the severely hearing-impaired. But Prof. Clark, who has been a target for this resentment in the past, says many strong advocates of sign language have begun to recognise the benefits of the bionic ear. “I’m pleased that there is no longer so much emotive resistance to the bionic ear in the signing community,” he said. “A more rational, considered debate is very healthy and welcome.” “I would hope that 80–90 per cent of children will be able to manage without the need to use sign language.” (O’Neill, 1999, p. 46)

Deaf Children

A search for the term deaf in the Factiva database yielded a surprising 8,074 hits. These were not analyzed in detail
because of the very large number of articles, but it seems likely that most of the hits were due to metaphorical use of the term as in “deaf to argument,” “deaf to pleas for leniency,” and the like. The search was therefore refined to the term *deaf children*, and this resulted in 348 hits. Of these, a number also occurred in the cochlear implant data and have been noted above. A large number of these were not directly relevant to the topic, being concerned with lack of funds for deaf education programs, court appeals against lack of service, descriptions of educational programs, stories about the Nucleus company and the inventor of the Australian implant, the need for universal newborn hearing screening programs, and so forth. Twenty-nine articles were descriptions of deaf education programs from both a medical and a sociocultural model viewpoint—more of them about oral programs and by inference supporting the medical model. Ten articles were primarily about cochlear implants and their Australian inventor and favored a medical model. Sixteen of the articles appeared to be in favor of the sociocultural model, and 13 presented a balanced approach with arguments for both models adduced without coming down particularly on one side or the other. Overall, as perhaps could be expected, it appeared that articles based on the search term *deaf children* were more balanced than those based on *cochlear implant*—30 tending to be in favor of the medical model and 25 the sociocultural model, whereas 13 presented a balanced approach.

Typical quotes from articles which appeared to favor the medical model included comments such as, “We are thrilled Katie will be attending a mainstream school when at times it seemed that it just wouldn’t be possible . . . It’s much better than the alternative of going to a special school” (O’Rourke, 2004, p. 61).

One particularly strong view of “deafness as difficulty/personal tragedy” was, “It’s obvious that members of the State Government have never experienced the physical or psychological effects of deaf children and the scars it leaves for life” (“Affected for life,” 2003, p. 17).

Despite a recent landmark ruling in Victoria that allowed a deaf couple to screen their IVF embryos for deaf genes, the Barton Smiths [Dean and Fran, a couple where the husband is Deaf and the wife hearing] would never want to “choose” a hearing child, they say. . . . Dean, who represented Australia at two Commonwealth Games and the Barcelona Olympics, is a senior executive of a national telecommunication company and completing a masters degree, is an example of how being deaf is no barrier to success. “I think what saddens me is that there is this continual misconception about deafness,” he says. “Having a hearing loss is manageable and you don’t die from it.” (Giglio, 2002, pp. 34–38)

**Discussion**

The above quotes indicate that over the past years emotions about the competing medical and sociocultural models of deafness engendered by the advent of cochlear implants have run high and engendered considerable press attention, and it is only recently that some rapprochement between cochlear implant programs and advocates (favoring the medical model) and the Deaf community (favoring the sociocultural model) may be beginning to occur (e.g., Bahan and
the “softening” changes in the most recent National Association of the Deaf Web site Position Statement on Cochlear Implants quoted above).

In articles discussing cochlear implants, the medical model of deafness predominated. Articles more generally about deaf children tended to be more balanced, but it seems likely that the reader of the Australian daily press would obtain the impression that the medical model is favored and deafness is something to be avoided if at all possible—by technology and regular school education. The possibility of living a viable Deaf life is rarely presented as an option.

It is of interest that none of the articles surveyed considered the possibility of having an implant and using signing. This would seem to be because almost all cochlear implants and early intervention programs in Australia adhere to the “auditory–verbal approach,” which is essentially unisensory in methods (i.e., as far as possible relying on audition only, minimizing visual stimulation, even via speech reading, much less signing, which is anathema to these programs because they believe it hinders oral skill development; Pollack, 1985; Simser, 1993; for a counter multisensory [auditory and visual input] view, see Power & Hyde, 1997). Despite some evidence that implanted children in signing programs with appropriate listening and speaking training do as well as children in purely oral programs (Spencer & Marschark, 2003), Australian implant programs typically will not accept children who have any association with signing and auditory–verbal early intervention programs will not accept children who sign or even have any association with a signing family, much less those who wish to attend a signing program (whether the method of communication be Signed English or Auslan). One father tells of such an experience with an Australian implant program (P. Hill, personal communication, November 30, 2004),

For [our son] to be implanted, we were told he would have to be taken out of [an Auslan-using preschool], plonked into an auditory–oral preschool environment, and deprived of all visual means of communication at home and elsewhere. We firmly believed, as we still do, that immersion of a deaf child into a visual environment at a very early age, as [our son] was, is an important factor in . . . defining that child’s character and personality. We simply could not deprive [him] of that environment. The cochlear crowd refused to proceed on a dual environment basis.

Interestingly, Hill went on to say that his own parents’ reaction to the news of the diagnosis of his first son as deaf was to send him a cutting about the cochlear implant:

I well recall my parents’ response . . . . a press clipping . . . about a 2 year old girl who had just been implanted. It was one of those upbeat, isn’t cochlear wonderful, deafness can be “cured”, now there’s hope for this poor little disabled child type articles. . . . It was my parents’ way of helping us deal with the issue.

Parents (and often grandparents and other members of the extended family) are at the center of the debate as it is the parents who have to choose whether their child should have an implant or not, often very soon after diagnosis. Parents usually have to come down quickly for one model or another. Because most parents are hearing and have no experience of childhood deafness, they wish their children to hear and speak and be normal and most choose an implant and an early intervention program that promises such outcomes. It has not been widely publicized that the outcomes are not achieved by a significant number of children (about one quarter to one third) who eventually have to come later to a signing environment (Hyde & Power, 2004). Hill’s experience is a good example of the dilemmas faced by parents.

We had been first advised to get [our son] implanted at the same meeting to discuss the results of [his] hearing tests. I can understand how easy it would be for parents to make such a decision in the absence of obtaining further information. Here you are being told some devastating news, but wait! There’s a “cure”! A parent desperate for their baby to be “normal” has to be influenced by this tactic. We were not in such a hurry. Or at least, I was naturally inclined to be wary of the speed at which we were being induced to make
such a decision (P. Hill, personal communication, November 30, 2004).

The results of this survey of these issues in the Australian daily press thus appear to be similar to those of Power (2003a, 2003b). Power found that the press appeared to take no consistent view in favor of or against a particular model of deafness. Much of the reporting was driven by “newsworthy events,” reporters’ and columnists’ general views of disability and disease in “the good society,” and the roles of individuals in that society, rather than any view of deafness models specifically. The good society would appear from these articles to be one that as far as possible consists of individuals who have no “biophysical maladaptations” (Hughes, 2000).

The impressions gained by the public and particularly the reactions to those impressions by hearing parents who suddenly find they have a deaf child are still problematic. Although the press presentation of these matters surveyed here is reasonably balanced, it is biased somewhat toward the medical model and as hearing parents want their children to be able to hear and speak like themselves, the overall impact of the press presentations may be toward reinforcing the medical model of deafness and the desirability of providing deaf children with a cochlear implant and an oral normal education in a regular school. It is likely that this sets an impressionistic background to influencing parental decisions about their deaf child’s future, but it is not known to what extent these articles actually influence parental decisions.

Although the press publicity sets a background tone to discussions of deafness, it would appear likely that advice from professionals in programs to which they are exposed at and soon after diagnosis influence parental decisions more than the more general background of press articles that they may have read some time previously (selected articles could be provided of course by early intervention programs to support the course they advise). This, combined with the fact that most diagnosis of hearing impairment is by medical and para-medical personnel and early intervention programs in most developed countries favor oral (nonsigning) education and rarely have members of the signing Deaf community on their staff, means that parents are presented with de facto medical models of what their child should be able to become. The implications of this for education of the deaf and the communication choices for life of deaf people need to be examined further.

Note

1. I adopt the now common convention of using “capital D—Deaf” to mean membership of the cultural and linguistic Deaf community. The “lower case d—deaf” stands for the medical/audiological condition of hearing impairment.

References

David is batting for Australia now. (2003, January 27). The West Australian.

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