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Chapter 3

Is There a Psychology of the Hearing?

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People make vocational choices for a variety of reasons—conscious and unconscious, rational and irrational, healthy and nonhealthy. This universalism is true for those who decide to enter any helping profession and, more specifically, for those who decide on a career of helping Deaf persons. Meadow (1981) noted that a hearing person's initial "missionary zeal" on entering the fields of working with Deaf people may productively fuel later accomplishments or may set the stage for eventual burnout.

As hearing students new to the "field of deafness," we study hard to learn the subject matter, about American Sign Language (ASL), the Deaf community, Deaf culture, and so on. We come to feel knowledgable and qualified to help Deaf persons, confident that we have something important to offer. We enter our respective professions with full gusto, with our hopes and dreams for a long and fulfilling career. Helping people is, after all, a noble profession.

Everthing seems fine until our bubble is burst. "Why so much hearing bashing from the Deaf community?" "Even many hearing people make me feel like I shouldn't be in the profession anymore!" We become angry. We become insecure. We question our motivations, our skills. We indeed question whether to remain in the field.

As hearing people, we may understand some of the dynamics behind hearing bashing as interwoven in a long history of opression of Deaf people by the hearing culture. And we remind ourselves not to personalize its content: "I certainly don't deserve to be called an oppressor just because of other hearing persons' behavior!"

This position has much merit. Why should a White person be blamed for slavery that happened more than 100 years ago? We should be innocent until proven guilty!

But nobody is completely innocent. We cannot help but incorporate and act out some of what we are continually exposed to in our culture. We are only partially successful at resisting the various "isms" that abound: sexism, racism, ethnocentrism, ageism, classism, and so on. At times, we, at best, unwittingly "oppress" our friends, lovers, and acquaintances in relatively benign and perhaps not so benign ways, and, in turn, those people oppress us.

An exploration of the the psychology of the hearing must include an analysis of our noble side, but not at the expense of acknowledging and understanding our "dark" side as well, our duality. In this context, our focus is not primarily to seek justice—who is right and who is wrong; who is the oppressor and who is the oppressed. We are both. There is a saying attributed to Mahatma Gandhi: "If you follow the old code of justice—an eye for an eye and a tooth for a tooth—you end up with a blind and toothless world." (cited in Johnson, 1991, p. 15).

The intent of this chapter is to take a hard look at the psychology of the hearing. The first part of the chapter examines some common reasons why we may initially become motivated to work with the Deaf. The second part of the chapter delineates common "relational postures" of hearing people toward Deaf persons, that is, predominate ways that we tend to perceive and behave toward Deaf persons. Each posture also implies ways that we perceive ourselves as hearing professionals.

In the third part of the chapter, we specifically address our attitudes and behaviors with respect to American Sign Language. We note that the continuing controversy regarding the importance of signed and spoken language is the central determinant that affects our relationships with Deaf people. Finally, the last part of the chapter describes what a collaborative relationship between Deaf and hearing people might look like. Some of the challenges to this collaboration are explored.

We base our conclusions on informal observations of our peers and on relevant literature. But our psychological examination is not only on those "others"; it must also necessarily include and be influenced by the psychology of the first author, as a hearing educator, and of the second author, as a hearing psychologist. For better or worse, we are all in this together. Hopefully, some of what is described will be generalizable to the reader and, to use a hearing metaphor, have "a familiar ring to it."

HOW DO PEOPLE BECOME INTERESTED IN WORKING WITH THE DEAF?

The first level of analysis is to describe some common reasons why we hearing people may decide to enter professions that are focused on the Deaf. This section describes seven such possibilities. Naturally, the categories are not exhaustive, nor mutually exclusive.

I Once Knew Someone Who Was Deaf: The Friend Decision

Probably the most common way to enter the field is through contact with a Deaf or hard-of-hearing person during childhood or early adulthood. Many professionals, for example, have grown up as a neighbor to a Deaf friend or had met a Deaf student in their schooling years. A relationship between a Deaf and hearing peer may be predominately one of dependency or it may be one of mutual exchange.

In a dependency relationship, the hearing peer chooses to befriend the Deaf peer but not necessarily the other way around. If the Deaf peer is in an integrated classroom and the children in the classroom are being taught sign language so that they may communicate with the lone Deaf peer, not all children will learn to sign equally well. Typically, as with people learning second languages, a small number of hearing students in the class will learn to sign rapidly and to some extent more fluently than most of the other students. Consequently, the Deaf student's decision to befriend particular hearing peers may be based more on their perceived capability of signing or interpreting than on whether the Deaf student wishes to befriend the hearing student per se.

Although this relationship may involve a high mutual exchange factor, it is ultimately built on dependency. The Deaf peer obtains an interpreter and a friend. It is the interpreting part of the relationship that makes for excessive dependency and that threatens to "pollute" the friend part of the exchange. Being in a position to control the language and the information flow between two parties puts the hearing student interpreter in a power-based role. Many times as children, the power is not consciously realized but is always there.

A mutual exchange friendship is the most difficult to arrive at between Deaf and hearing peers. As with all friendships, there must be some give and take, ups and downs, and positive and negative tensions. The Deaf person inevitably experiences circumstances probably not noticed by the hearing peer. For example, when a nonsigning hearing person attempts to converse with the Deaf peer, the actual conversation is often directed to the hearing peer who does sign. Phrases such as "tell him . . . " are signs of an imbalance within the conversational act. The challenge is to work out a mutually empowered way of handling such omnipresent temptations toward imbalances of power.

My Parents Were Deaf: The Parental Decision

Many children who have Deaf parents enter professions that are related to the Deaf. Many Children of Deaf Adults (CODAs), report that they have always known that they would become, for example, an interpreter, a teacher of the Deaf, and so on. It is also not uncommon for extended family members to encourage a CODA to pursue a career working with the Deaf because one is perceived to already possess the requisite skills. This was the experience of the first author, a CODA.

CODAs may believe that they possess a unique knowledge base about deafness and Deaf culture. As such, they may feel an ethical mandate to enter the field, as described later in this chapter. Other professionals attribute a special

kind of wisdom to CODAs. It is not uncommon for professionals to defer to peers with Deaf parents based solely on heritage. However, this bestowal of knowledge may or may not be deserved. It is frequently an extension of what was bestowed to CODAs as children; many questions were asked of them as young children that were beyond their understanding, but people assumed they knew the answer just because of their contact situation with the Deaf (Preston, 1994).

This situation provides one with a sense of power and control. This sense is possibly similar to the continuation of power and control one felt as a child who may have functioned as an adult in situations with their parents. But it is a double-edged sword, for this power and control often exceeds the person's self-perceived capabilities.

Intrigue With Sign Language: The Language Decision

Another common entrance into working with Deaf persons is when one becomes enthralled with American Sign Language. This may have been the result of having taken a course in sign, from having attended a signed play, or from having met Deaf people in a bar or other social gathering. The second author of this chapter, for example, saw a Deaf adult sign "America the Beautiful" and found it to be captivating, an impressive display of the sign abilities of a Deaf person. Although he did not have the skills to judge whether the Deaf person was in fact a good signer as regarded by the Deaf Community, nevertheless, he became intrigued with ASL. He described ASL as a "totally beautiful language" and therefore entered one of the fields working with Deaf people.

Indeed, sign language has been described as having great artistry and a ballet-like presentation of the movements. Because American Sign Language is in a different mode and done with the hands and arms, the articulator is in plain sight. It is not fundamentally different than a spoken language sounding pleasant to the ear.

Some people enter the deafness field via the language decision as a result of having chosen ASL as one of a list of languages in college. Some may have a propensity for learning languages, and ASL presented another linguistic challenge. Others have found it difficult to learn spoken languages, but assumed that, because sign language is in different mode, they could more easily become proficient in this language. Although they soon learn that their assumption was false, nevertheless, some become captivated by ASL and therefore by Deaf culture.

This latter point deserves special mention. Because learning American Sign Language requires at least tentative exposure to the Deaf community, many ASL students find themselves getting more than they bargained for at the outset. They may became intrigued with Deaf culture, overwhelmed by it, and so on. There are many possibilities. As soon as the professional learns to carry on a conversation with a Deaf person using sign, then further complexities arise with regard to the hearing person's view of their signing ability, their knowledge about the community, and their role within this new group of people. This is described later in the chapter.

A New Challenge: The Professional Challenge Decision

Professionals may become attracted to the field of deafness as a result of working with a Deaf client who required more help than they were capable of providing. This challenge may spark a fervor to identify new theories and techniques that can help that new population. Our fervor may, in fact, have primarily altruistic origins, as described in a later category. However, it is our experience that those in the helping professions are frequently expected to know all facets of their areas and how to assist all types of people, including the Deaf. Consequently, what may begin as altruism may be replaced by narcissistically driven behavior: Namely, one helps a deaf client because "no one is going to stump me!"

Some professionals in this category may enter the field because they are bored in their present positions and see this as an avenue out of boredom. The professional has a new field to learn about and is rejuvenated. Here, the professional's decision is also narcissistically driven.

It must be emphasized, however, that there is nothing inherently negative about satisfying narcissistic drives. Indeed, narcissism is hypothesized to be an omnipresent component of all human drives (Kernberg, 1984). One's level of awareness and psychological intactness are important factors. However, the possibility of narcissistic need satisfaction becoming oppressive is real and is described in the following category.

The Deaf Need My Guidance: The Dominant Colonialist Decision

Interest in the field of deafness sometimes has an "imperialistic flavor" to it. Deaf people offer new territories for the professional to conquer. One may even envision getting public recognition for new work in a new field. (We term this the "Noble Prize syndrome".) These professionals are able to gain power by working with the Deaf, power they would not have working with other hearing people. As an analogy, consider the case of a dominant colonialist, namely, a person who escapes from their own country and gains power over others by being in a position of political power.

The danger in the dominant colonialist posture is that one may devalue the opinions and sentiments of the Deaf community because they have become the object of one's narcissistic need gratification. Some, but not all, medical professionals display this view when confronted with conflicting views from Deaf people themselves. They discount the value of the opinion of Deaf people because of attributing their own medical opinion to be of a much higher order. Balkany (1994), for example, is an Ear, Nose, and Throat doctor (ENT) who wrote an editorial in the *New England Journal of Medicine*, actually stating that the Deaf community's opinion does not matter!

Identification With the Oppressed: The Outsider Decision

Many professionals have unresolved narcissistic wounds and identify with the problems of Deaf people. At a conscious or unconscious level, we attempt to "fill up" ourselves and resolve our pain by seeking to help Deaf persons cope

with similar issues of oppression and rejection. Miller (1981), in *Drama of the Gifted Child*, eloquently described this common plight of therapists: "It seems to me that if we [therapists] can do anything at all, it is to work through our narcissistic problems and reintegrate our split-off aspects to such an extent that we no longer have any need to manipulate our patients according to our theories but can allow them to become what they really are" (p. 22).

The positive outcome of this decision is for one to learn that narcissistic healing can only be done at a personal level and in a mutually intimate relationship with another (Jordan, Caplan, Surrey, & Stiver, 1991). In this case, what begins as co-dependent behavior by the hearing professional eventually catalyzes that person to "heal thyself."

How Can I Help? The Altruism Decision

The word *altruism* is rooted in the Latin *alter*, which simply means "other." August Comte has been credited with coining the term and conceived of it as devotion to the welfare of others, based in selflessness. Is such behavior possible? Skeptics such as Machiavelli, Hobbes, Marx, and Freud would argue that humans are incapable of acting out of any other motive than their own self-interest. On the other hand, Emile Durkheim believed that altruism exists in every society (Behhah, 1973). Lerner (1995), in a widely circulated journal entitled *Tikkun*, coined the term *politics of meaning* to emphasize that a latent need of U.S. society is to shift the dominant discourse from selfishness to caring.

People in this category feel touched by the needs of an outsider group, such as the Deaf community. They see a need and view their ethical mandate as requiring them to help. It has been speculated that a propensity for altruistic behaviors may originate in the value placed on caring in one's family of origin (Oliner & Oliner, 1988). One learns to extend one's boundaries of concern beyond oneself. It was Hillel who asked: "If I'm not for myself, who will be for me? If I'm only for myself, what am I?"

May God Be With You: The Religious Decision

The initial public entrance into the world of the Deaf community was first proposed by De Leppe and Gallaudet, members of the clergy. The funds raised for various programs and other missionary functions were received through the auspices that the Deaf people known at the time needed to be exposed to the word of God. Most religions hold this underlying missionary perspective.

There is a significant number of hearing persons who enter the fields that work with Deaf persons through contact with a religious structure. A professional could actually be a minister or cleric or be influenced by some function within a religious framework. Almost every religion in the U.S. has a section devoted to the Deaf population. It is through these sections that many hearing professionals learn that Deaf people need to receive the word of God. As a result, such professionals become interested in pursuing careers focused on assisting Deaf people in a variety of ways.

Professionals who enter with the missionary perspective must take care not to impose paternalistic behavior that can result in oppressive outcomes. This perspective, in its attempt to instill religious values, may unwittingly lead some to ignore or even display disrespect of the values of the Deaf world and many of the individuals within it. As an example, the helper might focus on speech and hearing skills that would shine a negative light on the use of a signed language. In contrast, for many Deaf adults, the use of a signed language can not only expose them to the word of God but is a means of empowerment.

The origin of one's motivation to work with Deaf people is typically multidetermined. One may be influenced by several of the previous reasons or others that are not listed. One may empathize with the Deaf community's outsider status with respect to the hearing world and simultaneously view working with Deaf clients as a new challenge. Moreover, one's initial reasons for entering the field are not static. One may first have altruistic motivations but later revert to dominant colonialism, or the reverse. As is described later, one may initially be impressed by ASL, only to later invalidate it.

COMMON HEARING "RELATIONAL POSTURES" TOWARD DEAF PERSONS

The reasons why hearing professionals initially enter the field of deafness may or may not correlate with their eventual perceptions of Deaf people or their behavior toward them. Moreover, their original intent(s) typically evolve into habitual ways of perceiving Deaf people, of perceiving hearing "helpers," and of behaving toward hearing and Deaf persons. We refer to these patterns of perception and behavior as "relational postures" that hearing professionals have toward deaf persons.

As with the listing of initial decisions to enter the field, there is the risk of oversimplification, and there is certainly significant overlap between these postures. The intent is to provide a heuristic framework for analyzing components of how and why hearing people perceive and behave toward Deaf people in certain ways.

The Freedom Fighter Posture

Some hearing professionals view Deaf people as the victims of societal oppression and, as such, honor an ethical mandate to correct that oppression. They become "freedom fighters." The freedom fighter is focused on righting the wrongs of society that have been perpetrated on Deaf people.

Consider the case of Children of Deaf adults. CODAs may be exposed to a number of circumstances in which the Deaf people in their young lives were subjected to extremely complicated and oppressive interactions by hearing people. The hearing child undoubtedly experiences a variety of emotions, such as empathy, compassion, helplessness, and guilt.

They may feel a false sense of power to correct the wrongs done to their parents. This sense of power, not necessarily conscious, sometimes leads to a variety of later behaviors. As one example, CODAs may be in the "business" of assisting other Deaf people to overcome societal oppression in order to ameliorate or resolve their childhood guilt. The positive outcome of this dynamic is that the work pursued by the CODA can be on behalf of the Deaf, for whom and with whom they are working.

As an analogy, Eli Weisel had witnessed his father being murdered by Nazis. For reasons that he himself acknowledges as irrational, he felt responsible. Partially, as a result, he has dedicated the rest of his life to ensure that no other Jews can similarly be murdered.

In both cases, those adults who had much earlier helplessly observed their parents undergoing oppression no longer feel as much helplessness as a result of saving like-others. They master their childhood pain vis-à-vis persons who come to symbolize their parents, more technically termed *transference objects*.

The effects of feeling powerlessness as a child and/or observing the powerlessness of significant others may emerge at different times under differing circumstances. One may be outspoken and driven while at other times be the mediator or peacemaker. If, as children, we have been put in many stressful situations out of our control, we may seek to gain power and control as an adult in order to avoid a reenactment of childhood anxiety. In the specific case of CODAs, this stance may also be encouraged by other professionals who defer or accord them special expert status. Additionally, one may serve as a "bridge" between both cultures, often related to one's mediation role in childhood.

Of course, there are many freedom fighters who are not CODAs, much like there were many non-Jews—so-called "righteous Gentiles"—who fought Nazism. We use the example of CODAs to note the prevalence of that relational posture among this group. As another example, Gunther and Harvey (1995) interviewed a sample of interpreters about those psychological factors that affect the quality of their interpreting. It was found that many interpreters—CODAs and nonCODAs—sustain their motivation to remain in the field because of their commitment to undo what they perceive as a wrong of society: an unequal balance of power between Deaf and hearing persons. They derive meaning from fulfillment of their ethical mandate to fight for freedom, for more equal participation.

It has been our experience that this posture accounts for at least one facet of many hearing professionals' involvement in the field. It is a double-edged sword, however, in that the freedom fighter posture may precipitate frustration and burnout when one has to accept limitations to change society (Meadow, 1981). Moreover, one may fight for Deaf persons' freedom while also operating from a variety of other relational postures, as described later. One, for example, may view both society and Deaf people as deserving blame. One may blur our boundaries while operating within freedom fighter posture.

The Pathological Posture

Our society honors those who work to "help" the less fortunate among us. Deaf people, like many other oppressed minorities, have always been considered to be of a lessor stock than hearing people. It is no wonder that to work with the

Deaf as a career is enhanced, supported, and highly rewarded. Witness the number of times one has been told that it "must be very rewarding to work with deaf children."

With this relational posture, one believes that the Deaf need the help of a hearing person in order to function well in the hearing world and avoid the horrors that may otherwise befall them. This way of thinking leads people to construct approaches, to build theories, and implement techniques that will "help" Deaf people lead better lives. The implicit framework assumes that Deaf people's lives are somehow negative and need help from professionals. This posture persists, even though a Deaf person may be depicted as having tremendous skills. Marlee Matlin, for example, in the popular television series "Reasonable Doubt," must have a hearing cop as an interpreter who not only interprets but helps her solve cases, and most importantly, helps her to function in the courtroom.

This posture also accounts for what many professionals who work with Deaf people erroneously term as "the psychology of deafness." Indeed, there are four major texts in the field, one published as recently as 1994, with exactly that name (Levine, 1960; Marschak, 1994; Myklebust, 1960; Vernon & Andrews, 1990). The notion of a psychology of deafness is really more about the psychology of hearing professionals who work with the Deaf (Lane, 1992; Vernon & Andrews, 1993).

This posture also leads one to discount the Deaf culture and community. Many professionals who are charged with the responsibility to advise, consult, and guide Deaf children and adults are totally unaware of the cultural, linguistic, and personal practices of Deaf people. Almost all programs that train ENTs, audiologists, and speech and hearing professionals include information about hearing-impaired people; yet, to our knowledge, these programs do not typically employ Deaf professionals as faculty or even have advisory or policy boards that have significant number of Deaf professionals as members. Nevertheless, these programs graduate professionals who are certified or licensed by national and state organizations.

Almost every professional certifying body that is connected to the Deaf has no Deaf persons as part of their boards. National Institute of Health, Institute for the Deaf and Other Communicative Disorders, the American Medical Association, American Psychological Association, and American Speech Hearing and Language Association, all of which control vast numbers of researchers and practitioners in fields relating to the Deaf, rarely have Deaf persons on their boards or any mechanisms in which Deaf input could be received and heeded. This results in decisions that hinder instead of help Deaf people in their everyday lives. They proceed under their own set of values that in many cases can harm Deaf people (see Mather & Mitchell, 1994).

This pathological posture is supported by the dominant cultural view that to be Deaf is something less than desirable. The medical profession, as a prime example, established a specialty whose sole purpose is to figure out how to correct problems of the ear. If the medical profession is unable to correct the problems of the ear, we will need teachers who will help the Deaf learn about the world. Then for those Deaf persons who continue to have difficulty learning about the world, we have mental health professionals who will help the Deaf cope with or adjust to the hearing world.

This poses enormous circular problems. How do we understand the idea of coping with the world? The idea of coping suggests there is a set of behaviors that one can learn to reduce the stress in one's life. However, the stress is defined by the hearing professionals, not by Deaf people. The focus of coping results in enhancing those skills felt to be deficient, that is, speech clarity, hearing acuity, and so on. Again those deficits are defined by the hearing professional.

When we hearing professionals fail at enhancing these skills, the fault resides with the problem of deafness and not with the values the hearing professional holds to be true. We now have gone full circle and did not even have to include the Deaf person in our helping framework.

The current discussion regarding cochlear implants is an example of this circular process. Medical, audiological, and manufacturing interests lobbied the FDA to approve the use of cochlear implants with Deaf children. In spite of no real evidence that they work better than a good hearing aid, there have been thousands of cochlear implant procedures done on children to date. Yet, this is a surgical procedure that implants a foreign, untested body into the skulls of children. The engineers who design the cochlear implant, the physicians who perform the surgeries, and the audiologists who test the results carry on these dangerous procedures without any valid evidence that the procedures work and that they enhance the quality of life of the Deaf person.

This type of professional does not have the Deaf person's interests at heart. They are essentially only interested in tinkering with technology. These professionals tend to have no contact with adult Deaf persons and receive little or no input from the Deaf community. They operate on the value that what they do is right and not open to question. In fact, such people receive accolades for performing "miracles" with Deaf children. The media works to support this idea.[1]

Blame the Victim Posture

How do people who bear witness to oppression explain its occurrence? Rather than attempting to make the world more just, as in the case of the freedom fighter, professionals in this posture instead blame the victim. "The Deaf must deserve their lowly status." This stance is phenomenologically similar to the pathological posture.

CODAs, for example, have spent much of their childhood bearing witness to such oppression. It is the first author's experience that some may resolve the resulting pain and rage by concluding that either their parents or their parents' friends may not have been very intelligent. This is based on listening to the hearing perspective of the Deaf person. The CODA may turn this belief into oppressive behavior equal to or greater than the oppressive hearing people who generated it in the first place.

[1] In 1994 on "60 Minutes", in a show called "Miracle Workers," there was a portrait of the doctors who surgically implant cochlear implants. These are devices that function like hearing aids but are surgically implanted in the head, instead of inserted in the ear. To date, cochlear implants have been found to be no more effective than high-powered hearing aids.

Some reactions to the Nazi persecution of the Jews provides an analogy. There are many Jews (and non-Jews) who criticize the Jewish victims for allowing themselves to have been slaughtered. "Somehow, it must have been their fault." In the case of rape victims, we often hear the sentiment that "she shouldn't have been in that bar in the first place", or "it was her fault for wearing those revealing clothes," and so on.

In the case of our views of Deaf persons, this oppressive behavior may be displayed in a variety of ways. We may perceive Deaf people as somehow lacking, that is, as "retarded" or as "lacking language." There are many other examples. The interpreter who mocks the Deaf person's poor signing skills; the teacher who does not think Deaf people should teach because their speech is not good enough; the professor who thinks that Deaf people should have tried harder to obtain English reading and writing skills equivalent to hearing people; the rehabilitation counselor who encourages Deaf people to accept low paying jobs because they are not motivated to obtain any better; and the psychologist who believes that Deaf people do not have the internal processes to explain how they function in different or difficult situations. Marschark (1994), for example, even suggested that Myklebust may have been right in his view of the Deaf person as being deficient; because they are Deaf, they will always need hearing people to reduce the deficiency.

Oppression, in the form of blaming the victim, may arise from attempts to resolve feelings of inadequacy and confusion when interacting with Deaf people. For example, a psychiatrist knowledgeable about the Deaf relates the following true story:

> A Deaf person requests a prescription for birth control pills from a psychiatrist. She complies and writes a prescription. The Deaf person goes to the pharmacy to fill the prescription. The hearing pharmacist is in a hurry; so, instead of taking the time to figure out what is needed, tells the Deaf person to go to room 510. Room 510 is the mental health clinic.
>
> The Deaf person, however, persists and tries to convey to the pharmacist what she needs by writing on a piece of paper. The pharmacist is flustered and becomes increasingly anxious. He therefore just waives the Deaf person away.
>
> By now the Deaf person is becoming upset. Yet the Deaf person goes to room 510, not knowing it is the mental health clinic. In the mental health clinic, the clinicians take care to speak loudly and with exaggerated mouth movements. They do not understand this young Deaf person's speech nor her "waving her hands." She becomes more agitated; because all she is looking for is to fill a prescription for birth control pills! The mental health professionals do not understand why a handicapped person is in their shop looking for birth control pills. They become confused and anxious.
>
> The mental health professionals then commit the Deaf person, without her consent, to an inpatient mental health ward. It took 3 days for the Deaf person to finally contact the psychiatrist who issued the prescription and get the matter straightened out.

The professionals, rather than admit their own communicative inadequacy, felt that the Deaf person should have been able to communicate through speechreading. The Deaf person was the problem, not that the professionals were unable to adequately communicate. The Deaf person, now labeled as

"patient," was given a diagnosis. Unfortunately, this scenario of not accepting responsibility and not showing basic respect for adequate communication is all too common. It is one of the most oppressive, and, in a certain respect, emotionally abusive acts that could be imposed (Mather & Mitchell, 1994).

In the same framework, there are professionals who do not sign well enough to understand the Deaf person yet refuse to use an interpreter. Instead, they blame the Deaf person for communicative inadequacies. Typically, these are hearing professionals who have had difficulty learning ASL or have chosen to use one of the artificial signed languages called Manually Coded English (MCE). Knowing how to sign using MCE does not provide the professionals with the skills to understand many Deaf people. When confronted by Deaf people, such professionals may feel unappreciated while internally knowing they are not very skilled. But they do not attempt to learn ASL or its linguistic structure. As a result, they may attribute various deficiencies to their Deaf students— blaming the victim—based on their previous training, mostly if not altogether from hearing professionals (Lane, Hoffmeister, & Bahan, in press).

This attitude is most evident in the education fields where many teachers (9 out of 10) who work in the mainstream, or non-Deaf centered programs, have learned about the Deaf from books in university training programs and have almost no contact whatsoever with Deaf adults outside of school (Woodward, 1990).

Mather & Mitchell (1994) related the following circumstance that they considered to be a form of communication abuse:

> Hector, age 17, is a deaf boy who attends a mainstream high school program. He uses sign language and attends regular classes with an interpreter. He has shown particular talent in higher math and photography. Recently, Hector visited his school guidance counselor to discuss college applications. Hoping to practice his signing, the counselor, who has only rudimentary signing ability, chose *not* to request an interpreter. Moreover, he felt that the Deaf student "should be bright enough to make do without one."
>
> Without an interpreter, the counselor was unable to understand Hector's requests during the meeting. After several attempts to make himself understood, Hector became frustrated, reached for a pad of paper, and wrote, "LEARN MORE SIGN!" He left the counselor's office angry and frustrated and vowed not to return without an interpreter. (p. 118)

Many Deaf people have had enough of this type of behavior when they were growing up. As adults they tend not to be as forgiving of such professionals as they were when they were younger. The Deaf community's understandable rejection sets the stage for a recursive cycle in which the hearing professionals, rather than tolerate and "contain" the blame, instead do more of blaming the victim. They may complain that Deaf people are ungrateful; "they don't recognize the hard work that we do." The more the Deaf community becomes empowered to act against hearing persons' oppressive behavior, the more hearing professionals experience a loss power and control. As a result, they may overeact by continuing that oppression in an attempt to disempower the Deaf community.

Idealization and Betrayal Posture

In contrast to the pathological and blame the victim postures, many hearing professionals in the beginning stages of their involvement with the Deaf community, idealize Deaf people. On television and in the movies, Deaf persons are sometimes portrayed as idealized giants; giants whose skill and prowess are impossible for the average Deaf person to achieve. Marlee Matlin, a recent and popular example, is seen on prime-time television as a Deaf person who not only understands lipreading at 50 paces but can understand someone signing to her back. Idealization of target groups in the media is not restricted to Deaf persons; consider how women are portrayed in various centerfolds.

This idealization posture, however, sets the stage for hearing professionals to experience betrayal. The idealized image, by definition, is an unrealistic normative stereotype of a Deaf person. When Deaf people are unable to live up to hearing persons' unobtainable expectations, they are viewed as flawed: "This is not what Deaf people should be!" Hearing persons, now perceiving Deaf persons more realistically, may experience a kind of shattering of their "Walt Disney" image and then may experience feelings of being let down or betrayed. This progression from idealization to betrayal is similar to what has been documented in regards to marital partners who experience the shattering of their idealized images of each other, along with subsequent feelings of betrayal (Dym & Glenn, 1993).

There is another common reason that neophyte hearing persons may initially idealize Deaf people. Much of the information professionals have learned from Deaf persons has been through the American Sign Language classes that are so prevalent today. Through this format, we are in awe of a new world that opens up to us in regards to the Deaf culture and community. We are shocked to learn about their historical and present-day rampant oppression. We may uncritically accept whatever cultural generalizations our initial Deaf teachers make. We take what they say as gospel.

This scenario also sets the stage for betrayal. At this date, only some of Deaf cultural information has been verified as having sufficient generlizability, and much of it is still in the form of "cultural notes." As more and more information is collected and the cultural notes become verified, many times the students outgrow the expertise of their Deaf teachers. Students find out that the cultural information they had received from their Deaf teachers may in many instances be incorrect. They may feel duped, angry, and let down because they have been led to believe that all Deaf people think this way.

This juncture also has implications for one's continued motivation to learn ASL. Feeling betrayed by the heretofore "idealized object," we now feel abandoned, angry, and burned out. We become frustrated and alientated in our work environment. It may be at this time that our initial fervor to master ASL often wears off. Beginning signers may feel that after a few classes they have learned "good enough."[2] Intermediate signers do not make the next effort to move to

[2]"Good Enough" is a sign frame used by Deaf people in both literal and figurative contexts. In its figurative context, it means that a person has done just enough to get by.

the next step and learn ASL fluently. For example, it is not uncommon for hearing teachers in preschools to have limited signing skills but state that they know enough sign to interact with their Deaf students.

A hearing professional may now lament, "how could they [Deaf people] view me as just another hearing oppressor in their lives?" We may feel hurt, righteously indignant, and rejected. We are ruefully reminded of our outsider status. We come to feel betrayed when learning that the Deaf do not really want nor appreciate our help. And we are confronted with the well-documented cultural phenomena that no matter how proficient we become in ASL, the fact is that we will always been seen as outsiders. Our initial hopes are shattered.

Rather than wallow in feelings of betrayal, professionals must grieve this loss; that it is always the case that full adoption by an oppressed group (Deaf community) of a member from an oppressor group (hearing community) cannot happen. We need to let go of the hope of being adopted by Deaf people and not subtly demand inclusion as a requisite for providing services. Moreover, therapists and other community workers are confronted with the possibility that they someday may not have a place in working with Deaf people. We painfully acknowledge that we cannot depend on Deaf clients for our income and must reconcile that Deaf people may someday not ask us to provide services.

The Cognitive Dissonance Posture

Cognitive dissonance occurs when a person cannot reconcile two or more conflicting beliefs, behaviors, or both. Consider the case of a professional who is beginning to learn sign language. In the second author's experience, having recently graduated from a Clinical Psychology doctoral program, I felt very proud of myself; and, in fact, I felt sort of grown-up, particularly when others referred to me as Doctor. But how was I to reconcile self-pride with the fact that, after several months of study, I couldn't even correctly sign "Good morning, how are you?" to a Deaf person? "Is it signed this way or that way?" "I thought my facial expression was correct." Having been confronted with my novice status, I became confused and anxious.

This is a typical example of cognitive dissonance for many neophyte signers. In this case, the cognition "I am proud and competent" conflicted with the behavior "I can't even correctly sign 'good morning.'" This dissonance produced confusion, anxiety, and lowered self-esteem.

Cognitive dissonance, with its attended confusion and anxiety, may also arise from misinformation about deafness. As stated previously in the idealization posture section, the available information about Deaf people is not always from reliable sources. Hearing professionals are trained in two major ways: through sanctioned, bureaucratic programs focusing on deafness and from informal, nonsanctioned individual Deaf people throughout the world. To our knowledge, it is still rare to find Deaf professionals training hearing professionals in anything other than sign language within the sanctioned programs. Partially as a result, the people who provide the training for professionals to work with the Deaf, in most cases, do not adequately know the subject matter.

Consequently, hearing professionals gain critical knowledge through non-sanctioned interactions with Deaf persons. We earlier described how this situation may encourage us to idealize the Deaf peer/professional. But, more relevant to the present discussion, it may also cause intolerable levels of confusion. We become confused because of questioning what we had earlier accepted as unequivocal truths. For example, one sign language student lamented, "One Deaf leader told me . . . about Deaf culture; but the other Deaf leader said that he was wrong; still another person said . . . about Deaf people. Which is it?" In this case, the dissonance was experienced as a result of two pieces of conflicting information from valued sources.

Cognitive dissonance also reigns when hearing professionals' own behavior comes into conflict with what they learn about the values of the Deaf community. Many professionals set out in a career path with practices that are in conflict with what Deaf people believe to be right. As one clinician put it, "What I have been recommending for twenty years with my deaf patients no longer matches with what I have come to believe is correct."

There are two common examples of this conflict or dissonance. The first example is the different cross-cultural values placed on residential programming for Deaf students. Deaf people refer to residential schools in a positive light and feel that such schools contribute to their feelings of community. Moreover, Deaf people frequently lament that many of their peers who have been in the integrated setting are really much more isolated and traumatized than their peers who attend large day and residential programs for the Deaf.

That view, however, is counter to hearing society's views of public education. Mainstreaming or inclusion is often viewed as temporary and positive by hearing parents and hearing professionals. They see this isolation from Deaf peers and signed language either as a necessary less-than-optimal situation, or they go so far as to see it as good for the isolated Deaf child to try and have hearing friends. In this regard, the number of hearing friends one has sometimes can be seen as a measure of success by hearing professionals who encourage parents to feel this way (Hoffmeister, 1985; 1993; 1994a, 1994b).

A second common value conflict has to do with different cross-cultural views of mental health. Briefly, hearing professionals may be caught between their own beliefs concerning the criteria of emotional adjustment and those of Deaf people. If Deaf children throw temper tantrums and are constantly seeking isolation from hearing authorities (or parents) who are unable to communicate with them, is this an example of emotional maladjustment? If Deaf persons do something not expected within the hearing world—that is, discuss things very bluntly or give the impression that they are overly critical—does this provide evidence of "mental illness?" To both queries, many hearing professionals would respond "yes", whereas many Deaf people disagree.

Effects of Cognitive Dissonance

When we cannot internally reconcile two or more conflicting beliefs or behaviors concerning the Deaf community, we may react in a variety of ways that are potentially dysfunctional for ourselves and destructive to the Deaf community.

Anxiety and deflated self-esteem are at the top of the list. As one clinician lamented, "Hearing that Deaf person lecturing us about how we're oppressors and what we've done wrong . . . pulled the rug out from under me!" Yalom (1989), an experienced psychiatrist in the hearing world, reflects on his own struggle, beginning when his new-found beliefs came to conflict with what he did in practice:

> How I long . . . for the certainty that orthodoxy offers. . . . Analysts seem more certain of everything than I am of ANYTHING. How comforting it would be to feel, just once, that I know exactly what I'm doing in my psychotherapeutic work—for example, that I am dutifully traversing, in proper sequence, the precise stages of the therapeutic process. But, of course, it's all an illusion. If they are helpful to patients at all, ideological schools with their complex metaphysical edifices succeed because they assuage the THERAPIST'S, not the patient's, anxiety (and thus permit the therapist to face the anxiety of the therapeutic process). The more the therapist is able to tolerate the anxiety of not knowing, the less need is there for the therapist to embrace orthodoxy. (p. 35)

Unfortunately, many professionals attempt to reduce their anxiety and assaults on their self-esteem by becoming angry at Deaf people. We may complain that the Deaf "do not want our help." We may feel that we have put in a great deal of time and effort into our careers and feel that Deaf people do not appreciate the good work that we do. Yet, we may continue to make decisions without even considering input from Deaf people. Or we become the professionals who search for that Deaf person who not only fits the stereotype (the needy deaf person, or [small d] deaf person who is not a member of the Deaf community) but who agrees with our perspective as hearing professionals.

Other professionals like hearing parents of deaf children may avoid Deaf people. Schlesinger and Meadow (1972) described the "shock, paralysis, withdrawal syndrome," referring primarily to hearing parents who first encounter Deaf people and sign language. Rather than tolerate and "work through" our dissonance between perceived self-competence and incompetent signing ability, we, sometimes literally, walk the other way when a Deaf person approaches.

More seasoned professionals may also avoid Deaf people. Although one's vocation may involve working directly with Deaf persons, there is an avoidance of contact in social or non job-related situations. Many professionals avoid contact with the Deaf community, using the rationalization that "I am too busy." Indeed, some separation of one's job and personal life is psychologically healthy and necessary to prevent burnout; and hearing professionals need to maintain healthy boundaries with the Deaf community. But avoidance of Deaf people is often in the service of anxiety reduction. In this case, professionals may withdraw from contact with persons who differ from their opinion and ignore any information that will conflict with the outcomes they view to be of high value, such as obtaining perfect English skills.

We stated earlier that one's reactions to dissonance may or may not prove dysfunctional and destructive. This section has focused only on negative outcomes. We later elucidate ways that one can make use of such dissonance as a way to develop healthy and respectful ways of working with Deaf people.

It is important to emphasize at this point, however, that there is nothing detrimental or oppressive about experiencing dissonance per se. What potentially becomes unhealthy and destructive is when we do not have sufficient awareness and understanding of how such dissonance affects our motivations to be of assistance.

Confusion of Boundaries Posture

Sometimes professionals overidentify and seek to become totally integrated in the Deaf Community. What begins as the outsider decision does not evolve in complexity but becomes one's sole raison d'etre. Such professionals frequent Deaf clubs and Deaf social gatherings, not so much for enjoyment or for an opportunity to enhance their sign language abilities but because they feel they are part of the Deaf Community. Particularly as professionals become more skilled in sign, they may easily fall into this trap.

It is a trap for two reasons. First, as elucidated elsewhere in this chapter, hearing professionals typically do not become part of the Deaf community. Thus, this endeavor is bound to precipitate frustration and burnout, perhaps culminating with the professional leaving the field. Or that stance will lead to a sense of entitlement, thereby leading to becoming blameful or resentful of the Deaf community.

Secondly, as helpers, we have to be mindful of the negative effects of internalizing the trauma that any oppressed minority group, such as Deaf people, has experienced. This phenomena is referred to as *vicarious trauma*. For example, McCann and Pearlman (1990) noted that psychotherapists who work with trauma victims on a regular basis often experience the same trauma symptoms, including burnout and diminished functioning. Boundary regulation becomes particularly important in order to psychologically protect oneself. Gunther and Harvey (1994) found that interpreters frequently sustained vicarious trauma from interpreting situations in which a Deaf person was oppressed. The quality and intensity of the interpreters' responses were influenced by their degree of involvement with the Deaf community and transference acting out with respect to earlier emotionally laden experiences. Common vicarious trauma reactions included fear, anxiety, depression, anger, rage, guilt, shame, and lowered self-esteem. For example, one interpreter felt an overwhelming sense of guilt when the deaf consumer was ignored during a meeting, even though his interpreting was flawless. The etiology of his guilt had to do with having witnessed his father abuse and ignore his sister during their childhood. In a transferential sense, the deaf consumer had become his sister.

Overidentification also may lead to feeling overneeded. As we gain the respect of the community, our own evaluation of our skills is naturally enhanced. As we come to feel needed, we may unwittingly come to rely on helping others in order to gain self-respect. Such co-dependent behaviors include taking on too many roles. Consider the example of an mainstream classroom interpreter who is sometimes the Deaf student's teacher, tutor, confidant, and counselor. Or consider interpreters who feel that they are so important to the students that they cannot take a personal day off to attend a friend's wedding. Their feeling is that, without their expertise, the students cannot succeed on their own (Nover, 1994).

At the other extreme of overinvolvement and overidentification, some professionals erect too rigid boundaries between themselves and the Deaf community. They put in 40 hours a week working with Deaf people but do not question their work, nor take much pride in it. Typically, this person does not sign very well and has difficulty communicating with Deaf adults and Deaf professionals. This inability to sign well may turn into a rigid pattern whereby all communication is conducted in a manner determined by the hearing professional. Many such persons use English-based signs and assume that "I can make myself understood." It is extremely disheartening for people who have been working with the Deaf for many years to admit they do not have the requisite language skills to be understood by, and to understand, most of the Deaf adults in the community.

We may engage in coalescing activities among themselves in order to gain support for our behavior and maintain our self-esteem. We may gather together in a hearing group that is clearly defined, that is, teachers who support signed English and resist learning ASL. We may informally get together to complain about Deaf people. Whereas it is necessary and healthy to form our own hearing support groups, it is detrimental to engage in groups in lieu of any dialogue or input from Deaf professionals or the Deaf community. This is analogous to the harmful effects of professionals who assist AIDS patients without requesting any input from the AIDS community.

There are many reasons why we may erect too rigid boundaries. We may silently or vocally ridicule Deaf people as in the blame-the-victim posture. We may become angry that "they don't act grateful" as in the pathological posture. There are many possibilities. As the second author illustrates later in this volume in chapter 6, "Utilization of Traumatic Transference by a Hearing Therapist," we may emotionally "numb out" in order to protect ourselves from becoming overwhelmed by Deaf persons' pain. Such "affective constriction" is a common vicarious trauma reaction.

THE LANGUAGE PARADOX

An analysis of the "psychology of the hearing" must specifically address hearing persons' attitudes and behaviors with respect to American Sign Language. The omnipresent debate and lack of acknowledgment regarding what role sign language and spoken language play and their importance to Deaf people are the central, overriding factors relating to the adequacy of all interactions between hearing and Deaf people. However, many times hearing professionals do not even understand the issue of communication and its importance. A hearing person's lack of American Sign Language skills is among the top topics that constantly cause damaging cross-cultural interactions and that cause Deaf persons to harbor acrimony toward hearing persons.

As stated in the first section of this chapter, for many hearing professionals, it was sign language that prompted entrance into the field. However, it has often been those very people who end up changing the language, not for the Deaf but for themselves. Hearing professionals changed from ASL-based education to

oral education to make it easier for themselves in the latter part of the 19th century and then, in the mid-20th century, changed from oral to an English-based sign system not for the Deaf but for themselves. This is the central paradox or hypocrisy.

Many of us, except CODAs, have learned about the Deaf from books and university training programs. Yet in many texts, the fact that most of the Deaf community knows and uses American Sign Language is usually ignored, down played, or denigrated (Hoffmeister, 1993). This central issue then is often left to the individual discretion of professionals who make decisions about how to communicate with their Deaf clients and how to advise hearing parents to communicate with their Deaf children.

Although American Sign Language is taught to thousands of hearing college students, it is not a preferred language within the mainstreamed educational community for use by Deaf persons. It is not explicitly stated as such, but reference to ASL is usually through the use of the term *communication*. When researchers and professionals wish to refer to English, the more respected term *language* is used; but when they wish to refer to some signed form, they use the term communication. The use of the term language as a euphemism for English is misleading to new professionals who are not aware of the historical context. These professionals then may become indoctrinated to this usage and insidiously invalidate ASL in favor of English. Our own language influences our perceptions, as exemplified by the recent movement to use *African American* instead of *Black*, *woman* instead of *girl*, and so on.

To be able to sign covers a wide-ranging set of skills. To be able to sign can mean that a person is able to find a sign (the lexical frame) for each English word as it is spoken. Because there are not lexical signs for all the English words, many signs are created to fill this gap. This type of signing behavior falls under the heading of manually coded English (MCE). To understand MCE you must know English. This makes it easy for the professional but extremely difficult for the Deaf child or adult who is not that fluent in English. These professionals are able to sign or produce a visual form of English but are not understandable to most Deaf persons.

At the other end of the continuum is the person who learns ASL, the language of the community. This person is able to produce ASL in the language structure and forms of the people who use it. To reach real fluency in ASL, however, requires years of training and interaction with Deaf people. Much like non-English languages, one must be encased in the culture and community of users to become fluent. It is here that many professionals who work with the Deaf have difficulty. The time it takes to become a fluent user of the language may conflict with the time needed for career and family obligations. There are many professionals who are working with only a small number of hours dedicated to learning ASL.

Consider the situation of mental health professionals who provide clinical services for Deaf people. Those professionals who are known to have proficiency in sign language receive all the requests for information about the Deaf. Yet there is no systematic way to determine whether those who say they can sign can really sign well enough to perform at the level the job requires. But because the Deaf community has been ignored for so long and hearing people tradition-

ally have not learned to sign, the new generation of professionals who allegedly sign are welcomed. This is especially true in rural areas away from major metropolitan centers.

Moreover, referrals regarding Deaf people are made because a clinician can sign, not because that clinician may have the expertise in the area of inquiry. Hence one begets honors from both Deaf and hearing communities for having expertise in the area of the Deaf. Once referrals begin to come in and solutions to many problems are found, some professionals may feel they know more than they have actually been trained to do. As one becomes more respected for helping Deaf clients, the feeling of having expertise is great.

There is a myth that to transfer information from one field to another, especially with the Deaf, all one has to do is add the sign language. This has been done within the area of psychological testing for the past decade. Yet this is full of pitfalls and errors. There is more than just the language issue that is in need of transfer (Hoffmeister, 1988). Cultural and individual backgrounds combined with the variety of Deaf persons make the "transfer" issue extremely complicated.

HEARING–DEAF COLLABORATION

How can hearing people help promote constructive dialogue across the Deaf and hearing communities? The beliefs, values, and attitudes of the Deaf community need to be delineated. To date the fields working with the Deaf have not taken the time to sufficiently find out what the average Deaf person believes to be true or helpful. It is ironic that in the past 100 years there have been very few surveys and almost no research of Deaf views that could lead to a cultural description of the community; there have been few, if any, surveys as to which beliefs the average Deaf person holds as to how the communities function and interact; and no surveys as to how the general beliefs about educational history, social history, and emotional history have influenced their lives (Kannapel, 1993; Rutherford, 1993).

Consequently, Deaf professionals must create a circumstance to review information that is disseminated to ensure its reliability and validity. Hearing professionals must ensure that the information we receive from Deaf individuals is information applicable to the community as a whole and not to individual circumstances. In short, we must share the goal of obtaining empirical, generalizable "truths."

The beliefs, values, and attitudes of the hearing community also need to be delineated. As Sue, Arredondo, and McDavis (1992) articulated in reference to the ethics of culturally affirmative therapy, therapists must actively engage in the process of becoming aware of their own assumptions about human behavior, values, biases, preconceived notions, personal limitations, and so forth.

However, as with the Deaf community, to our knowledge there have been no systematic studies or treatises on the psychological dynamics, or relational postures, of hearing persons with respect to the Deaf community. As a result,

we witness still rampant oppression, including misuse of psychological tests and inappropriate psychotherapy that have been described in this text. The failure to examine the psychology of the hearing makes for a dangerous situation. This chapter is meant to be one step in rectifying that direction.

As we have described, hearing professionals need to examine those reasons that prompted us to enter the field and remain in it; and most importantly, we need to discuss what we do professionally with both Deaf professionals and other Deaf persons. It is a complicated process of acknowledging that one's original, often unconscious, relational postures with respect to Deaf people may not lead to optimal ways of helping. In therapy lingo, we need to "work through" why we are working with Deaf people. We can then remain in the field and do service to it.

The reader interrupts: "But why are you preaching that we hearing people need to work through anything? Maybe you do, but do not put that on me!"

As stated in the introduction to this chapter, there is a lot of merit to the frequently voiced comment, "I'm not an oppressor, and I'm tired of being convicted and executed as guilty, never to be proven innocent!" Although, on our better days, we understand hearing bashing by some Deaf community members as a necessary step in their equalizing the heretofore unequal distribution of power, it nevertheless does not feel good. In fact, it feels damn unfair!

Again, as earlier stated, in our opinion, we hearing professionals need to acknowledge that the content of hearing bashing has some truth for us, at least some of the time. Like it or not, we are members of a majority who have taken, and have been given, a lot of power to define the lives of Deaf persons. We inevitably incorporate at least cultural "baggage" that surrounds us. One is never not prejudiced. Like it or not, one is both a saint and a sinner, an oppressor and a liberator.

Alexander Solzhenitsyn said it best: "If only it were all so simple! If only there were evil people somewhere insidiously committing evil deeds, and it were necessary only to separate them from the rest of us and destroy them. But the line dividing good and evil cuts through the heart of every human being. And who is willing to destroy a piece of his own heart?" (cited in Zweig & Abrams, 1991, p.).

Awareness of our "evil or oppressor side"—what Jung termed *the shadow*—can help us not act on such impulses at any given moment. We recall watching one of our favorite Star Trek episodes in which Captain James T. Kirk was asked by an alien to kill another person in order to save his own life. He refused. The alien was puzzled and said, "But I thought you human beings were naturally killers!" Kirk, with his usual dramatic flare, replied, "Yes, humans are indeed killers; but we don't have to kill *today!*" Our challenge is not to oppress *today*!

Let us return to the question of how to establish constructive dialogue between the Deaf and hearing communities? An analysis of the worldviews of each group is insufficient. An adequate understanding of any relationship cannot be accomplished by simply understanding the individual participants, whether these participants are at the micro-level of a dyadic relationship as between a therapist and client, or at the macro-level of society as between two groups of people. As systems theory teaches us, "The Gestalt is more than the

sum of its parts." Something else happens when two or more individuals interact; a quality emerges that cannot a priori be predicted. We can only speculate.

We now engage in that speculation, in a sort of "wishful thinking" about what a collaborative relationship with Deaf people might look like. Hearing professionals would not work for the Deaf but with the Deaf. Exchange of information and cross-cultural fertilization will enable both communities to understand their compatible and conflicting approaches to serving the Deaf population. There would be a discussion of real needs, an equal exchange of ideas and information, and a cross-cultural understanding of how hearing and Deaf decisions affect the Deaf community. Deaf people would have equal authority to determine policy and sometimes more authority, especially if the decisions will determine life circumstances of Deaf persons.

Easy to say but hard to do. The thorny issues and challenges are now only beginning to be more clearly defined, in part, because Deaf professionals and lay persons have become more empowered. The issue of power is one such "thorn." Although the situation is changing, all too often, the professional's power has been uncontested. Whatever decision the professional made was deemed right because there has been no sanctioning group to judge its equitibility. The hearing professional too often has been both the judge and jury. As we have detailed, one can become a power person in this business without ever having contact with the people one has power over (Hoffmeister, 1994a, 1994b).

Deaf and hearing professionals must co-create a mechanism for exercising a shifting balance of power. Much like any dyadic relationship, one person or side may hold more power at any given time. Each side must be able to change roles in order to accommodate the shifting contextual requirements. For example, many times the initial relationship between a Deaf and hearing professional is one of teacher–student: The Deaf person teaches the hearing person ASL. Complicated interactions may occur when the hearing student progresses and then begins to provide information to the teacher. This shift requires role flexibility on the part of both the hearing and Deaf person.

Other examples of shifting roles include a clinician who is providing treatment to a current or previous Deaf teacher; a vocational rehabilitation counselor who makes decisions regarding a Deaf client who was at one time his or her teacher; and a classroom teacher who is learning ASL from a former student. In each instance, power is redistributed, at least temporarily. The issue of dual roles for therapists is a complicated one and is discussed in the introduction chapter by Glickman (Chapter 1, this volume) and the chapter by Zitter (Chapter 8, this volume).

These forms of role switching can cause great dissension within the relationship and potentially creates a vulnerability in both parties not encountered before. For example, the hearing therapist who had earlier been taught ASL by his/her Deaf client may note that the now Deaf client is not progressing as quickly as anticipated. The result is role reversal with its inevitable discomfort. Both hearing and Deaf professionals must learn to judge whether they indeed can switch roles. A common impediment is when the hearing or Deaf person

had earlier idealized the other and now must see each other in a different light and renegotiate the rules of their relationship.

As another common instance of the need for role switching is when Deaf people are either functioning in an "amateur" framework or are in a profession controlled by hearing people. This structure is typical. Many hearing professionals who are part of this structure should carefully examine how or if they are helping to establish the atmosphere and conditions that facilitate empowerment of Deaf people. Specifically, it is often helpful to establish structured dialogues to mediate cross-cultural conflicts and to point out to the administration when procedures are, perhaps without intent, discriminating against Deaf people.

The major impetus for the shifting of roles and power between Deaf and hearing persons has been Deaf empowerment. Deaf people have begun to become empowered and want rights, authority, and control of Deaf-related programs and institutions. The Gallaudet revolution (Deaf President Now Movement) of 1988 is a quintessential example. Although, at times, empowerment of Deaf persons has been occurring with the support of hearing professionals—ironically with the exception of the Gallaudet revolution—we often find this to be a difficult and confusing process. It is tough to acknowledge that, as a consequence of Deaf empowerment, the Deaf will want our job or at the very least, a share of our job's power. It is inevitably tough to relinquish power.

Part of what makes recognition or Deaf empowerment difficult and confusing at the professional level has to do with the issue of affirmative action. On the one hand, institutions and agencies are appropriately hiring more Deaf people, including at administrative capacities. On the other hand, hearing and Deaf professionals must take care not to hire unqualified Deaf employees simply to fill quotas. West (1993) stated, with reference to the African American community, that many African American people are left wondering if they are being hired based on merit or based on a quota. Affirmative action can empower as well as disempower an oppressed minority. To make matters more confusing, many Deaf people require training to understand various administrative roles and the role of culture within the professional roles.

There remain many unanswered questions. Who has the expertise to train qualified hearing individuals? What are the qualifications of hearing and Deaf persons who can, as objectively as possible, facilitate cross-cultural exchange? Who will sanction these individuals? Who will supervise the hearing people in the business? Will hearing people allow Deaf professionals to supervise them? With the Deaf empowerment on the rise, *can* hearing people work side by side with Deaf people? Can Deaf people begin to trust hearing people?

CONCLUDING THOUGHTS

Hopefully this chapter has provided some elucidation of our psychology; a mirror of sorts that shows us our internal experiences as we first entered and now remain in a field working with Deaf persons. We acknowledged our altruistic, pure side; our healthy and unhealthy narcissistic side; and our dark

side, our need to control, pathologize, and blame. We then wondered how we can appropriately work with Deaf people in ever-shifting roles.

Is there a psychology of the Hearing? Of course not, just as there is no psychology per se of the Deaf (Chess & Fernandez, 1980; Lane, 1992). However, there are common psychological dynamics of oppression, as discussed in the introductory chapter, that seem to go with being a member of an oppressor majority as well as an oppressed minority. This chapter has outlined those attitudes, motivations, needs, and behaviors that we hearing persons, as members of the oppressor group, often display.

With this psychological mirror, we can acknowledge both our rational and emotional reactions to changes in the Deaf community. We can co-create a safe place or, in Winnicott's (1965) terms, a "holding environment," with other Deaf and hearing people in order to understand and "contain" our experience. In other words, we can support each other to feel and act in ways that are healthy for us as well as for those Deaf clients that we serve.

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