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Language in Medical Worlds: Hearing Technology for Deaf Jordanian Children

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Language in Medical Worlds: Hearing Technology for Deaf Jordanian Children

Bringing together medical and linguistic anthropology, I examine the provision of hearing technology, such as cochlear implants, to deaf Jordanian children, a project animated by an imperative to make deaf children speak. Drawing upon ethnographic fieldwork at a cochlear implantation initiative and an audiology department in Amman, I argue that this imperative must be understood in relation to anxieties about the status of Arabic in Jordan and the historical value of orality in the Middle East. This case shows that more attention must be paid to the role of language ideologies in co-constituting medical encounters between clinicians, parents, and patients.

Keywords: Jordan; cochlear implants; deafness; ethopolitics; language ideologies; sign language

من خلال الجمع ما بين الأنثروبولوجيا الطبية والأنثروبولوجيا اللغوية، لقد قمت بتقصي توفير تكنولوجيات السمع، مثل أجهزة القوقعة الاصطناعية، للأطفال الأردنيين الصم، وهو مشروع سبب انشاؤه هو الضرورة للمساعدة بجعل الأطفال الصم يتكلمون وينطقون. بالاعتماد على العمل الميداني الإثنوغرافي في مبادرة زرع قوقعة الأذن بالتعاون مع إحدى أقسام السمعيات في عمان، أجد أن هذه الضرورة يجب أن يتم تفهمها فيما يتعلق بالمخاوف بشأن مكانة اللغة العربية في الأردن والقيمة التاريخية للشفهية في الشرق الأوسط. تُظهر دراسة هذه الحالة أنه يجب تخصيص المزيد من الاهتمام لدور الإيديولوجيات اللغوية في تشكيل لقاءات طبية ما بين الأطباء وأولياء الأمور والمرضى.

I am sitting in the corner of one of the isolation rooms in the audiology department in the Ammani hospital, where audiologists conduct hearing tests for the many patients, young and old, who come to the department. My notebook is out, but otherwise, I am trying to be as inconspicuous as possible as I watch one of the audiologists, Nour,¹ conduct a hearing test with Rahab, a six-year-old girl who was surgically implanted with a cochlear device four years prior, in 2015. The cochlear implant aims to provide people who have hearing loss with some access to sound by delivering electronically processed audio signals directly to the auditory nerve and then to the brain. This is one

of a number of hearing tests I have witnessed since I obtained the “medical training” (*al-tadrib al-ṭibbi*) security permit that allowed me to begin my ethnographic research at this Jordanian hospital just a week before.

Rahab’s parents are worried about her because, although she does not seem to have as much of a problem hearing, she is not speaking as well or as clearly as she should. “*Al-mushkileh nuṭuq*” (the problem is pronunciation), they tell Nour before the hearing test. Rahab’s mother is in the isolation room with us, and expands on this problem, saying that Rahab can pronounce some sounds better than others, but has issues with certain Arabic letters—*nuun* and *zay*, for example. Part of the hearing test also involves testing speech, and Rahab’s mother tries to get her to say *kelb* (dog), but Rahab only manages *keb*. Frustrated, Rahab’s mother begins crying. She badly wants her daughter to speak well and has been trying to train her—throughout the consultation, for instance, I have seen her often prompt her daughter to say particular words, “Say ‘mama’” (*iḥki mama*) or “Say ‘thank you’” (*iḥki shukran*)—but it is difficult, and people have even told her that she is being too hard (*qasiyyeh*) on her daughter.

She wipes her tears away as we wrap up the hearing test and go back to the office where Nour and another audiologist give Rahab’s mother and father advice on how to improve Rahab’s speaking, including making sure that she goes to two types of speech therapy: “*ḥaraf*” (letter), which focuses on producing particular sounds, and “*luḡha*” (language), which focuses on producing words. Rahab would benefit especially from the former, they tell her parents, and, if she keeps working on it, they will see improvement in her *speech*.

In this article, I explore the politics surrounding the provision of hearing technology to deaf children in Jordan, drawing on ethnographic fieldwork that I

conducted in Amman in the summer of 2019. The provision of hearing technology to deaf Jordanian children is not a straightforward project, but an aspirational, affective one, fraught with emotion—hope and disappointment, relief and stress. Such technologies are inflected with normative and moral expectations about what parents should do with their deaf children and what they can expect if they undertake that work. They are also intimately bound up with questions of language, communication, and expression, as seen in the opening ethnographic vignette. The numerous encounters I witnessed between parents and audiologists during my fieldwork revealed to me that hearing technology for deaf children—whether hearing aids or cochlear implants—is more about *speaking* than it is about hearing in Jordan. With the use of these technologies, hearing is enlisted in service of speaking and is useful only insofar as it can help deaf children produce legible speech.

This ethnographic fact, which is rooted in an oralist language ideology that elevates speaking over signing, is at the heart of the argument I make in this article. The audiologists who were my interlocutors were very much invested in making deaf children speak, to the exclusion of other communicative practices like sign language. While the notion that intervention and rehabilitation for deaf children in medical spaces focuses on their production of speech is not new (see Blume 2010; Mauldin 2016), what I hope to demonstrate in this article is that this oralist ideology takes on especial salience in the context of growing anxieties in Jordanian society about an alleged decline in the use and status of Arabic and a historical emphasis on the value of orality. Just as “there are many ways to be deaf” (Monaghan et al. 2003), there are likewise “many ways to be oralist”²—as I will explain, the Jordanian way emerges out of a particular history associated with Arabic and speech in relation to both religious histories and concerns about cosmopolitanism.

In this article, I follow Briggs and Faudree (2016) to think about how medical anthropology and linguistic anthropology might be productively combined to analyze the dynamics of providing hearing technology to deaf Jordanian children. Specifically, I use this Jordanian case to demonstrate how a tool like “language ideology”—as theorized by Irvine and Gal (2000)—might enrich sociologist Nikolas Rose’s theory of ethopolitics (2001, 2007), which does not go far enough in considering how beliefs about language co-constitute medical encounters between clinicians, parents, and patients. I use ethnographic data to examine how oralism as a language ideology functions in the medical spaces in which I did fieldwork and how it is shaped by the broader cultural politics of Jordan, which, as part of the Arabic-speaking Middle East, sees an intense set of language ideologies centered around the language and its spoken life. Debates about correct language occur everywhere and frequently, and the audiology department was no exception. The provision of hearing technology to deaf children in Jordan is a story of medicalization, to be sure, but it is also one that is enfolded with a language ideology that links speaking Arabic with being Jordanian and that permeates those medical spaces where deaf children are treated.

In the rest of this article, after a brief explanation of my research setting and methods, I examine the productivity and limits of ethopolitics as a frame of analysis for how deaf children—and their parents—are interpellated into becoming medical subjects. I then draw upon language ideology as a tool to explain how cultural specificities relating to the importance of speech and orality in Jordan shape the provision of these technologies.

Research setting and methods

In recent years, the Hashemite Kingdom of Jordan has made concerted efforts to ensure the rights of its citizens with disabilities, whether physical or mental. In March 2005, it

was awarded the Franklin Delano Roosevelt International Disability Award by The Roosevelt Institute and the World Committee on Disability for the progress it had by that time made toward the goal of the United Nations World Program of Action Concerning Disabled Persons. This award, created in 1982, aims to encourage the full and equal participation of disabled people in their societies. Jordan was the sixth country to receive the award and the first and only Arab or Islamic state to do so (Rutherford 2007:25).

More recently, in 2017, Jordan passed a new law ensuring the rights of people with disabilities. A number of scholars have suggested different reasons for this shift away from a charity-based model to a rights-based approach towards the question of inclusion, including Jordan's policy of investing in its citizens as a resource; its openness to foreigners (Rutherford 2007); or its participation in larger projects of aligning with liberal-modernist global frameworks of social development (Sargent 2019; cf. Adely 2009). This is not to imply that charity-based projects cannot coexist alongside contemporary neoliberal projects, but that the dominant approach in Jordan towards the inclusion of disabled Jordanians has moved from one where the object of intervention is a pitiable person to be helped to one where they should be "developed" into a productive citizen, just like their non-disabled peers. Development in this case refers to the transformation of disabled citizens into a population useful for the state's economic productivity (Mitchell and Snyder 2015), what David Mosse calls "big-D development" (2013:228; cf. Sargent 2019), in contrast to the production of signing-centered deaf worlds, as in Michele Friedner describes in her 2015 book, for instance.

Part of this shift to ensuring the rights of deaf Jordanians includes the recent establishment of a state-affiliated cochlear implantation initiative, which heavily subsidizes the provision of cochlear implants to eligible Jordanians. Over summer 2019,

I spent six weeks doing ethnographic fieldwork in the capital of Amman, two weeks interning at the office of the initiative, and another four weeks at the audiology department at the hospital in Amman with which it partners.³ Although the first cochlear implantation surgery in Jordan actually took place in December 2003 in collaboration with a German physician, the partnership between the initiative and the hospital only began in 2010; earlier, citizens who wanted cochlear implants had themselves to bear the full cost associated with the devices. The number of cochlear implantation surgeries has skyrocketed in the last several years, with 1170 surgeries conducted since 2014, according to the initiative's promotional video. The increasing use of the cochlear implant and medicalization of deaf children is not exceptional to Jordan, and has been documented across multiple national contexts, including the United States (Mauldin 2016), India (Friedner 2018), and Mexico (Pfister 2019), among others. These processes are not locally bounded but unfold in transnational networks of medical care.

During the first phase of fieldwork at the office of the initiative, I worked with another intern and under the direction of our supervisor to produce promotional brochures for the initiative, focused on criteria for implantation, early screening, and post-operation procedures for cochlear implant candidates. Some of this material was based on our own research, while the rest was from internal policy documents in Arabic that we read and summarized in English. As an "observing participant," I felt some unease, as I was helping to produce discourses about cochlear implant technology even as I analyzed them.

During the second phase at the hospital, I observed everyday operations in the department: hearing tests; cochlear implant mappings; consultations between audiologists, patients, and parents; and even two cochlear implantation surgeries.

Outside of office hours, I also occasionally spent time with deaf Jordanians I had come to know during previous stints in Jordan, primarily in deaf spaces in Amman where Jordanian Sign Language (LIU, from the Arabic *lughat al-`ishara al-`urduniyya*) was the dominant communicative medium. This was most often at a deaf cultural center in the city that had weekly gatherings for deaf Jordanians that included basketball games, lectures, and other social activities.

In all these spaces, I conducted participant observation, taking extensive fieldnotes, in addition to informal, conversational interviews with my interlocutors in everyday life. Although my initial goal was to focus solely on the cochlear implant, my research came to resemble more the method of multi-sited ethnography, tracing cultural formations across multiple sites of observation and participation, an approach that lends itself well to the complex and geographically disparate processes of assembling participation and publics around science and technology (Fischer 2003). Cochlear implants fall along a spectrum of hearing technologies in Jordan, which take on different “social lives” (Appadurai 1986) in different settings. That is, what the hearing aid or the cochlear implant means for a deaf person in a deaf social club is different from what it means for a parent of a deaf child at home or an audiologist in the hospital, and it changes even as the user moves through these different spaces.

A word about positionality before I continue: I am a hearing doctoral candidate in the anthropology of science with deep engagement with deaf communities in Singapore, the US, and Jordan, and ethical and political commitments to the notions of Deafhood (Ladd 2003) and Deaf Gain (Bauman and Murray 2014), which broadly posit deafness as benefit rather than deficit.⁴ In the vein of critical medical anthropology and disability studies, I am wary of biomedicine’s “moral imperative” (Colligan 2004) to “fix” people with disabilities, although I position my work in deaf anthropology rather

than deaf studies in its studious avoidance of essentializing deaf lives (Friedner and Kusters 2020). I hope my own background will illuminate rather than obscure my analysis in this article. Following Laura Mauldin’s scholarship on cochlear implantation in the US (2016), I aim ethnographically to illustrate the logics that underpin the rationalization and circulation of these technologies in Jordan and their reception, avoiding “an anthropology of easy enemies in which the tools of ethnographic engagement are wielded to attribute blame and produce affect in a manner that elides nuance and complexity” (Knight 2015:30). I therefore do not intend to pronounce in any normative way on whether hearing technology is “good” or “bad” for deaf children.

I am proficient in Arabic and conversational in LIU, although neither are my first language. Following Green (2014), I see successful communication between my interlocutors and myself as a result of mutual moral orientations toward each other, linguistic commensuration emerging from a shared desire to communicate. Generally, I found myself using English in the office, Arabic in the hospital, and LIU in deaf spaces, although these languages did cross over into the other spaces.

The ethopolitics of hearing technology: understanding the imperative to speak

As my fieldwork progressed, I came to understand that the cochlear implant (*jihaz al-qawqa‘a*, often glossed as simply *al-qawqa‘a*, which refers to the actual cochlea organ) falls along a spectrum of hearing technology in Jordan, with hearing aids (*al-samma‘at*) on one end—less expensive, less invasive—and cochlear implants on the other—more expensive, more invasive.⁵ While most laypeople think of the cochlear implant and the hearing aid as devices that function similarly to improve hearing—differing in degree but not in kind—how they work is starkly different. The hearing aid is an external device that amplifies sounds coming into the ear and relies on the user’s

existing hearing faculties. The cochlear implant, on the other hand, comprises an external and an internal component, of which the latter must be implanted surgically. The external component contains a microphone that picks up sounds and transmits them to the brain via the internal component as electronic signals.

The cochlear implant creates a sensation of sound quite different from ordinary hearing, a point made clear in the initiative's promotional material. As stated in the post-operation brochure:

Unlike a hearing aid—which amplifies sounds from the environment—a cochlear implant bypasses the ear entirely and creates a perception of sound that is different from that created by the ear. Therefore, the child needs to learn how to use it to understand speech.

Note here the focus on speech, which both hearing aids and cochlear implants are meant to provide access to.

Only when hearing aids were deemed ineffective for a child, however, would the child be considered eligible for the cochlear implant, which was a more invasive device than the hearing aid—it requires surgery and a much higher degree of auditory and speech training than the hearing aid. Parents with young deaf babies who came to the department looking to get cochlear implants were asked if they had tried hearing aids yet, and were told that they would need to do so before their child could get cochlear implants—it was the “last solution,” as a senior audiologist, Ahmad, told me, and for many other children, “hearing aids were enough,” and they did not need the more invasive intervention of the cochlear implant to hear and to speak.

This was made clear when Amjad, a three-year old boy who had just started using hearing aids five months before, came in with his mother. She, Ahmad, and Mahmoud, another senior audiologist, discussed the possibility of a cochlear implant for Amjad, and they told her that he needed to get used to sound before he could get an

implant. It did not look like to the team that Amjad was “comfortable” (*murtaḥ*) enough with the hearing aids at the moment, which meant that he did not yet seem accustomed to having some degree of sound exposure or to wearing the devices. I asked Mahmoud about Amjad afterwards, and he told me that, although the cochlear implant is technically free of charge because of sponsorship from the initiative, hearing aids may sometimes be better in the long term, because the cochlear implant requires maintenance (*al-ṣiyana*) and training on how to use it. A child might occasionally get a recommendation for a cochlear implant “late” (*mit’akhir*) because the department initially wants to see how hearing aids can benefit (*bitfid*) the child.

The notion of “benefit” (*istifada*) permeates the everyday language and functioning of the audiology department. For example, during the period I was there, the department only had hearing aids for mild and moderate forms of hearing loss available, and patients who came in asking for hearing aids for severe or profound forms of hearing loss were told they would not benefit (*ma bistafidu*) from the hearing aids that the department currently had in stock and should come back in the near future when their stock had been replenished. As in the case of Amjad, the parents of deaf children were also told that only when a hearing aid no longer benefited their child’s hearing would their children become eligible for a cochlear implant. This is similar to the situation in the US, where cochlear implants are not a “first-line” treatment but requires that parents try other methods of intervention like hearing aids first (Mauldin 2016:27).

How deaf children would “benefit” from these technologies, however, was measured narrowly, and understood primarily in terms of how hearing technologies would benefit them to hear and to speak (*fi istifada bsir* hearing *bsir* speaking), as Mahmoud told me during my initial orientation to the audiology department. There was

no sense, for example, in which these technologies would help deaf children to hear environmental sounds or give them a greater sense of deaf identity. In everyday conversations, the audiologists would draw an explicit and inextricable link between the two skills of hearing and speaking, even though they are in fact separate. One audiologist even drew a causal link, telling me while referring to one of the young deaf girls that had come into the department, “*lazim tisma ‘ashan tiḥki*” (she needs to hear so she can speak) and that if the child did not acquire speech during the period of language acquisition, they would end up speaking like a robot (*tiḥki zayy rajul ‘ali*).

Indeed, the provision of hearing technology to deaf children is predicated on a particular neoliberal, promissory logic: that the right actions taken by parents with regard to hearing technology in the present will lead to the future success of their deaf child, even as that success is measured primarily in terms of the extent to which those children are able to *speak*. The imperative for deaf children to speak is bound up in the *ethopolitics* of hearing technology in Jordan.

Ethopolitics, a formulation of sociologist Nikolas Rose, is an elaboration of the Foucauldian notion of biopolitics (1978), and refers to “the self-techniques by which human beings should judge themselves and act upon themselves to make themselves better” (2001:18) that arose at the onset of the twentieth century. In neoliberal fashion, with its emphasis on individual self-making, health becomes primarily an individual responsibility, to be secured through correct, health-seeking behavior. I find ethopolitics helpful to understanding the Jordanian case I study here in three ways.

Firstly, as Rose argues, one crucial difference between contemporary ethopolitics and the biopolitics that came before is that the rationale for the political interest in health is no longer a geopolitical concern but cast rather in economic or moral terms (2001:5–6). As stated in the post-operation brochure, “The earlier that the

child gets a cochlear implant, the lower the *costs* incurred by the parents, resulting in a need of fewer speech therapy sessions and a lower time *investment* from the parents” (emphasis added). The reference to “costs” and “investments” here—the language of economics—demonstrates that distinction and indexes the modernist nature of this project (cf. Murphy 2017).

Secondly, central to ethopolitics is the notion of “risk,” which Rose writes “denotes a family of ways of thinking and acting that involve calculations about probable futures in the present followed by interventions into the present in order to control that potential future” (2007:70). The notion of “benefit” in the case of hearing technologies in Jordan is structured around similar logics to those found in “risk politics” (2001:1) that differentiate between and hierarchize individuals and groups that might benefit more or less from a given intervention. These logics use a particular vision of the future—the speaking child—to justify interventions in the present, even as this future is uncertain and predicated on “a big ‘if,’” as all promissory ventures are (2007:89). This discourse of the future is particularly explicit in the promotional video on the cochlear implantation initiative’s website. Set to inspirational music and filled with hopeful images of deaf children receiving cochlear implants and engaged in everyday activities with other (presumably hearing) children, the video promulgates a vision of the future where deaf children, if only they are implanted, might integrate fully into Jordanian society. As the cochlear implant is put onto a child’s ear, the voiceover states, “Today, many have been implanted with hope” (*inzara ‘ fihum al- ‘aml*)—cleverly, the script uses the same Arabic word for “implanted” here that is used for “cochlear implantation,” analogizing the device itself to a form of hope implanted into a life that was by implication previously hopeless. The video ends on an explicit reference to the future: as a young deaf girl writes in her notebook and her father applauds her

efforts, the video proclaims, “The future... is definitely more beautiful!” (*al-jayy... 'akeed 'ajmal!*).⁶

Thirdly, a claim about hearing technology in Jordan as “ethical” not only obscures the wildly variable outcomes of cochlear implantation (cf. Kral et al. 2016) but also the labor that is required for the realization of this vision of the future speaking child. Rose points out one paradox of ethopolitics—that under this neoliberal regime, “we are obliged to work on ourselves to make ourselves what we really are” (2007:117). As the opening ethnographic vignette reveals, the efforts of parents are paramount to the successful speech of their deaf children: they must commit to bringing their children to speech therapy, track their speaking progress while at home, and even perform a kind of pseudo-speech therapy. While interning at the initiative, my fellow intern told me a story that she had heard from our supervisor about a woman who was so dedicated to her child’s speaking success that, even though she lived too far from the closest therapist to go there regularly, she did her own speech therapy at home with the result that her son now speaks fluently, even though he was implanted relatively late, at age three. These narratives take on a kind of mythic quality, lionizing the “right” kinds of parents—those who are committed to their children’s speaking success—and naturalizing outcomes that are in fact variable and often dependent on education, socioeconomic class, access to resources, and other such factors (cf. Lin 2019). Indeed, one of the eligibility requirements for the cochlear implant, as stated in the initiative’s brochure for parents, is that “the beneficiary has at least one hearing and speaking parent or has a first-degree relative who is willing to follow up with the beneficiary and keep track of his/her progress in speech therapy.” As Mauldin has masterfully shown in the North American context (2016), the burden of ensuring that implanted deaf children speak falls on their parents as “trainers,” and particularly on mothers.

However, in this Jordanian case I study, the notion of how deaf children “benefit” from these technological interventions is intertwined with broader notions—consciously or subconsciously held—about the nature of language and speech. For example, since research outcomes demonstrate that deaf children implanted earlier have better speech outcomes than those implanted later (e.g. Tomblin et al. 2005), the former are given priority over the latter when it comes to receiving an implant. In fact, deaf Jordanian children who had not acquired language (specifically, speech) before a certain age were deemed ineligible for the cochlear implant, because it would not “benefit” them. An audiologist explained to me that a three-year old boy who had just been implanted a few months prior also had a sister who had recently been implanted, but that she would not benefit like he would (*ma tistafid zayy hada*, referring to the boy) because she was already six or seven years old, past the critical period of language acquisition (*iktisab al-lugha*).

Thus, while Rose’s ethopolitics helps to elucidate the promissory logics that undergird the provision of hearing technology in Jordan, it does not fully take into account the significance of the oralist language ideology that animates beliefs and practices around what counts as “proper” embodiment for Jordanian deaf children, who, as my audiologist interlocutors insisted, must speak.⁷ Understanding why speech and spoken language matter so much in Jordan, and the broader Middle East, is the focus of the next section.

Language ideologies in medical worlds: Sign language and Arabic in Jordan

The beliefs that the audiologists who are my interlocutors hold about sign language and speech are not value-neutral but part of an oralist language ideology that elevates speech over sign language, rooted in the historical value accorded to orality in the Middle East. Importantly, as linguistic anthropologists teach us, language ideologies are as much

about beliefs about language themselves as about how these beliefs become naturalized through configurations of power (Woolard and Schieffelin 1994). Tellingly, the Arabic word for pronunciation, *nuṭuq*, which appeared in the opening vignette and can also refer more broadly to speech, shares the same lexical root with *manṭiq*—logic, diction, eloquence—pointing to a semiotic association between good elocution and the faculty of the mind.

The valuation of speech over sign in this cochlear implantation initiative was demonstrated most starkly when my fellow intern and I were preparing the post-operation brochure and had included a section with tips for parents with children who sign. Because we had included a section on sign language in the early screening brochure that had been approved, we were taken aback when our supervisor told us to remove it, explaining that it is not a service that the initiative provides and that they did not want to make it seem as if they were supporting it. “The best option is cochlear implants with speech therapy,” she said, “and putting them into ‘normal’ schools.” This was true also in the hospital, where the audiologists did not know sign language or even much about the language at all, and parents were told by speech therapists that signing with their children was “not allowed” (see Loh 2021).

This language ideology that insists upon the superiority of speech over sign has historical roots in oralist traditions that view sign language as a bastardized form of language (cf. Polich 2013) and thus a barrier to full linguistic personhood, a perception that has only begun to shift since linguistic research beginning in the 1960s that has demonstrated the “language-ness” of sign languages (Armstrong and Karchmer 2009). Since the late 1800s, this misconception of sign languages as not “real languages” has also led to a long history of deaf children being denied access to using and learning sign languages (through physical punishment, for instance), including in Jordan (Al-Fityani

2010:20). Are the discourses about speech and sign among Jordanian audiologists continuations of such traditions, albeit in forms that *seem* more benign (even though they might not be, given the risk of language deprivation for deaf children without access to either signed or spoken language)? After all, outside of medical settings, Jordanian Sign Language is not banned and a version of it is technically used in Jordanian public schools for the deaf—though it is not well integrated pedagogically, as Al-Fityani (2010) documents; it is merely regarded as the poorer of two otherwise seemingly equivalent options, the last resort for those who fail to hear and speak, even with the aid of technology.⁸

To be clear, I am not arguing that this particular configuration of language in medical spaces only exists in Jordan; Friedner (2018), for instance, discusses sign language as “virus” in a center providing speech and hearing services in Cochin, India where different language ideologies push up against each other. In that space, to many parents, “signed languages are framed as pollutants, sources of contamination, and transgressions that must be constantly guarded against” (366). In fact, many of the same ideologies about sign language seem to pop up everywhere; the notions that sign language is not a real language, that it is the “easy way out,” that it is universal, for instance, are widespread across multiple contexts,⁹ and I saw some of these beliefs during my fieldwork too. Nor am I suggesting that such beliefs about sign language are monolithic throughout Jordan: sign language was a source of pride and value at the Ammani deaf cultural center I spent time in, for example, as well as at a signing deaf school where I conducted fieldwork in 2014 (cf. Al-Makhamreh 2016; Hendriks 2008).

What I am suggesting, however, is that the dominance of this oralist ideology in the medical spaces I studied takes particular form due to cultural and historical specificities relating to speech and orality in Jordan and the broader Middle East. The

imperative for deaf Jordanian children to speak is exacerbated by contemporary anxieties about the declining role of Arabic as the hegemony of English as the language of education, cosmopolitanism, and general upward mobility increases. Considered “the global language” or “the language of business,” entrepreneurship trainees in Jordan are told by NGOs, for example, that they need to learn English to succeed in business, because no banks would accept business plans written in Arabic, as Maysoun Sukarieh has documented in her ethnographic work (2016:1211). For others, the rising status of English in Jordan has generated fears about “the disintegration of Arabic-speaking individuals from their own mother tongue” and a “linguistic identity crisis” (Alomoush 2021:56).¹⁰

It is significant here to point out that the cochlear implantation project I study is part of a cluster of initiatives under a state-affiliated foundation, and that one of the other initiatives run by the foundation is a language preservation project within Jordan. One of their promotional videos makes a concerted effort to connect the Arabic language to vital aspects of the nation, stating, “Our language is our identity, the language of the Holy Qur’an, the language of our civilization and our revolution, the language of literature and of sciences (*al-‘ulum*), a sea of words in which is our existence and our future.” Such rhetoric may seem like an exaggeration or overly dramatic, but it is perhaps warranted, for another video reveals that “46 percent of Jordanians are embarrassed to speak in Modern Standard Arabic, and 33 percent of them state that Arabic with the addition of English technical terms would be more elegant (*‘arqa*) and would give more value to their speaking” (*yu ‘ti qima ‘akthar lil-kilam*). In light of these worries about Arabic in Jordan as expressed by an initiative run by the same state-affiliated foundation in charge of the cochlear implant initiative, I argue that it is no coincidence that a language ideology that valorizes speech over sign

language would be so dominant, as speaking Arabic becomes intertwined with being Jordanian.

To explain how this language ideology functions to link Arabic to Jordanian identity, I turn to Irvine and Gal's (2000) influential tripartite division of linguistic differentiation into the semiotic processes of iconization, fractal recursivity, and erasure. The conflation of speaking Arabic and being Jordanian, I argue, is an example of *iconization*, which "involves a transformation of the sign relationship between linguistic features (or varieties) and the social images with which they are linked" (37). In this case, iconization naturalizes the link between the national language and national belonging, to the exclusion of other languages within Jordan, not only LIU but other minority languages as well, like Armenian and Caucasian dialects like Chechen and Circassian.

This process of iconization also involves multiple instances of *erasure*, "the process in which ideology, in simplifying the sociolinguistic field, renders some persons or activities (or sociolinguistic phenomena) invisible" (Irvine and Gal 2000:38); the aforementioned minority languages are a case in point. But Arabic is also unique because of the coexistence of Modern Standard Arabic (MSA), used for education, politics, and other formal situations, alongside a number of colloquial dialects that differ from country to country and are the vernacular of everyday life. While most sociolinguists of Arabic now disavow the oversimplistic dichotomous framework of diglossia to characterize this situation (Haeri 2000:64–67), MSA is still understood by many to be the correct form of Arabic, and the colloquial dialects "impediments to 'progress' that needed to be overcome 'exactly like poverty and disease'" (63). Indeed, the failed project to unify the Arabic sign languages across the 22 Arab countries that Al-Fityani documents was justified on the basis that MSA allegedly "unites the different

members of the Arab community, despite the different geographies and cultural traditions that can be found throughout the region” (2010:44). As can be seen even in this language preservation project in Jordan, Arabic is treated as monolithic; the existence of multiple vernaculars is erased and Jordanian Colloquial Arabic is folded into the label “Arabic,” even though this label as used by the foundation clearly refers to MSA. In this semiotic process, “facts that are inconsistent with the ideological scheme either go unnoticed or get explained away” (38). Which Arabic is it, then, that deaf children given hearing technology should learn? Under this language ideology, it does not matter; Arabic is Arabic, and it is still better than sign language.

This language ideology bundling national language and national identity also recurs throughout the broader Middle East, which accounts for how Arabic can stand for both a Jordanian national identity as well as a pan-Arab identity. *Fractal recursivity*, according to Irvine and Gal, “involves the projection of an opposition, salient at some level of relationship, onto some other level” (2000:38). Whether true or not, the fear that the use of Arabic is declining in Jordan has salience not only within the Kingdom but also throughout the region where language preservation projects have proliferated, like the Qatar Foundation International’s Arabic Language program. In understanding these language anxieties at a regional scale, I am inspired by Chen (2010) and Fan (2016) to think about “Middle East as method”; I do not mean to imply a flattening of differences in countries across the region but merely to state my belief that similar worries about the status of Arabic are widespread across the Middle East. While expressed anecdotally, they have not been as well-documented in the academic literature (but see Haeri 2000:63 about concerns over “foreign borrowings” into Arabic, as well as Lian 2020). In recent years, the spread of English across the world has only accelerated changes in the sociolinguistic make-up of the region and heightened anxieties about the role of

Arabic. It is important to note here also that these fears of a declining mother tongue because of English are not unique to the Middle East, but further recur in other contexts where English is not the native language, especially in the Global South—what Robert Phillipson has called a “linguistic imperialism” (1997).

The dominance of oralism in the provision of hearing technology to deaf children in medical spaces is further shaped, I argue, by religious ideologies in the Middle East that have historically placed a strong emphasis on orality and Arabic as the language of the Qur’an and of Allah himself. It is no accident that one of the promotional videos made by the language preservation project begins with a verse from the Qur’an: “Indeed, We have sent it down as an Arabic Qur’an that you might understand” (*la ‘allakum ta ‘qilun*).¹¹ The use of Islamic discourse in Jordan is especially significant: since its founding by British fiat in 1921, the royal Hashemite family has based its legitimacy to rule in part on its Islamic credentials, emphasizing their lineage from the prophet Muhammad, their status as protectors of the Muslim holy sites in Jerusalem, and their role as purveyors of a particular vision of Islam (Adely 2012:298).

That audiologists believe that deaf Jordanian children should speak and hearing technology should provide them with the ability to do so, then, should not be surprising, given the paramount importance of orality in premodern Ottoman Syria and Egypt (of which Jordan was a part) since at least the sixteenth century. In that context, “Severe hearing loss was generally viewed as a misfortune, but it did not inevitably constitute an insuperable impediment to participation in social and economic life. The inability to *speak*, on the other hand, was by all indications just such an impediment” (Scalenghe 2014:49, emphasis added). Orality’s centrality stemmed from the role it played in multiple domains, not only the transmission of knowledge in education but also in the verbal agreements of everyday business and in the memorization and recitation of the

Qur'an. Furthermore, good speech was not only regarded as instrumentally important but, in the period following the founding of Islam in the seventh century, carried a moral import as well:

The Prophet Muhammad is reported to have ordered members of his community to correct the speech of one of his followers, telling them that deviation from the norms of correct speech is a form of *ḍalal* (deviation from the right path) . . . In a similar vein, Abu al-Aswad al-Du'ali (69/688) . . . likened incorrect speech to the foul smell of rotting flesh or meat. (Suleiman 2012:204)

It is worth reiterating here, that this language ideology emphasizing orality centered around *speech* and not deafness per se, which was not perceived “as [a condition] bearing intellectual, religious, or moral stigma” (Scalenghe 2005:21).

While the world certainly has changed since then, not least the Middle East, this language ideology emphasizing orality has a long history in the region and continues to influence the present day—and, in my case, is enfolded into the provision of hearing technology to deaf Jordanian children. To give just one other example: based on fieldwork conducted in Yemen in the 1970s and 1980s, Brinkley Messick argues that there is a “privileging of the spoken word” over the written word in Muslim societies, what he terms a “recitational logocentrism” (1992:25). The paradigm for this logocentrism is the Qur'an, which is at its basis a recitation-text that was received in an oral form by the Prophet Mohammed.

Conclusion

I end this article with a story about my deaf friend Faisal, a 28-year-old adult signer who uses neither hearing aids nor cochlear implants and who grew up in a signing deaf family. For Faisal, such hearing technologies were marked by ambivalence. He told me that these hearing technologies had both good and bad aspects, but that his concern was

for deaf children who are stuck if they get a cochlear implant and do not succeed in hearing schools but cannot go to deaf schools either because they do not know sign language. “Technology is fragile and can fail,” he explained, which was why he believed that sign language was ultimately still important for many deaf children. During my fieldwork, there was at least one deaf boy I encountered, a five-year-old, whose cochlear implant was broken (*kharban*), according to his mother, and he could neither speak nor sign and was unable to communicate easily with anyone. His case demonstrates the consequences of the oralist language ideology in medical spaces in Jordan that I have traced in this article, which is problematic both developmentally and socio-politically. The focus on the acquisition of orality and speech for deaf Jordanians, to the exclusion of other forms of language and communication, can result in deaf Jordanian children not being able to communicate—in any modality—as well as their having a diminished sense of belonging to broader deaf collectivities.¹²

I have here sought to analyze the politics of hearing technology provision to deaf children in Jordan through the dual lens of medical and linguistic anthropology. I drew upon ethopolitics to examine this process of medicalization, pointing to both its productivity and its limits, and argued that it could be strengthened by using language ideology to explain the embedding of oralism within this process. Specifically within Jordan, I argued that the notion held by many of my interlocutors in medical spaces that deaf children must speak is a language ideology rooted in the historical role of Arabic in the Middle East and as well as the fears engendered by the rising status of English vis-à-vis local mother tongues in the region. In recent years, scholars have pointed to the deficiencies of theories formulated in the Euro-American context for the Global South, where alternative configurations of access to political and economic resources produce different epistemologies and ontologies (Comaroff and Comaroff 2012; Friedner 2017),

and I hope this Jordanian case might be one example of how local conditions might generate different worlds.

Paying attention to the role of language within medical encounters is important, I argue, because language is never merely about communication. Rather, both spoken and sign language are *articulations*: “of language, culture, and sociality [that] foster new forms of affiliation as well as new senses of self and belonging” (Friedner and Helmreich 2012:80). As I have demonstrated in this article, the provision of hearing technology to deaf children in Jordan can reveal how biomedical imaginaries, neoliberal logics, and ideologies about linguistic modalities might converge and mobilize to mold deaf children today to the image of the successful speaking citizen of Jordan’s future.

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NOTES

¹ All names have been changed. I also deliberately avoid naming the hospital and program I worked with.

² I thank Michele Friedner for this helpful framing and for this particular turn of phrase.

³ Given the short duration of the fieldwork, I recognize the provisional nature of the arguments I make in this article, though I do put forth the claims here with some degree of confidence, having lived in Jordan for two years prior to starting the doctoral program and having spent time in deaf communities in Singapore, the United States, and Egypt in addition to Jordan. I hope that I will be able to deepen and extend my analysis after completing dissertation fieldwork.

⁴ In deaf studies, there has been a tradition of using “deaf” to refer to those with a physical condition of hearing loss and “Deaf” to refer to those with a cultural and linguistic identity centered around sign language. In this article I use “deaf” to encompass both physiological and sociocultural connotations so as not to circumscribe the experience of deaf people in the Middle East with that of North America and Western Europe (cf. Scalenghe 2014:8).

⁵ There are at least two other devices that fall somewhere on this spectrum: bone conductive implants, for which deaf Jordanians could technically qualify; and auditory brainstem implants, which an audiologist told me are not used in Jordan because they are considered “dangerous,” since the implant is placed directly on the brainstem rather than in the cochlea, as with the cochlear implant. During my fieldwork, neither of these cases came up, and it was clear that hearing aids and cochlear implants were the dominant technologies in the hospital.

⁶ I thank Marah Sarji for help with translating the Arabic videos, although any translation errors remain mine.

⁷ I acknowledge that Nikolas Rose himself formulated these concepts in the context of “advanced liberal democracies” (2001:18) and perhaps did not intend for them to be applied elsewhere.

⁸ In fact, Jordan has signed and ratified the Convention on the Rights of Persons with Disabilities (CRPD), which promotes the use of sign languages. To me, what this points to is a tension between a right to medical care and a right to accessible language. See also Friedner (2018) for an explanation of the trope of “oral failures.”

⁹ For an introduction to sign language ideologies from a sociolinguistic perspective, see Hill (2013). Sign language ideologies in various contexts around the globe is also the subject of a recent volume edited by Kusters et al. (2020).

¹⁰ I want to caveat that the concern over losing Arabic to English is a classed issue in Jordan—for the purposes of this article, suffice it to say that the issue is generally more salient among Jordanians of a higher socioeconomic status.

¹¹ Qur'an 12:2, trans. Sahih International. *'aql* here is the opposite of *jahl*, referring to *al-jahiliyya*, or pre-Islamic Arabia. The implication is that people come to know Allah through the Qur'an.

¹² This article has focused primarily on the views of the hearing audiologists with whom I conducted fieldwork. In my dissertation research, I hope to explore the issues I have raised here in this article from the perspectives of deaf Jordanians, which are likely different from those of hearing Jordanians (cf. Kusters et al. 2020).

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