Serving Clients With Hearing Loss:
Best Practices in Mental Health Counseling

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According to the National Association of the Deaf (NAD; 2003), more than 28 million Americans have some degree of hearing loss. Three out of every 1,000 infants are born with a hearing loss, the most prevalent birth defect in the United States (National Center for Hearing Assessment and Management, n.d.). Individuals with hearing loss vary greatly depending on individual degree of hearing loss, age of onset, use of assistive devices, and means of communication. Individuals with hearing loss are also diverse in respect to economic status, age, gender, sexual orientation, and ethnicity. This article first provides an overview of the characteristics and risk factors of the population who are deaf and hard of hearing and then discusses several counseling models and interventions for mental health counselors serving clients with hearing loss to use in addressing and minimizing these risk factors.

Client Characteristics and Risk Factors

Individuals with hearing loss are too often socially isolated within their homes, schools, workplaces, and communities. Common barriers individuals with hearing loss face include communication problems, inequitable access to health care and education, low literacy, and underemployment. As a result of familial and personal conflicts, spoken or unspoken, and peer and societal discrimination, individuals with hearing loss often feel inadequate and alone, with few resources and means of support. Individuals with hearing loss often have to acculturate to the hearing world, resulting in a loss of personal identity and group identification. This is particularly true of persons with hearing loss who are gay, lesbian, or transgender; immigrants; minority status citizens; and individuals from lower socioeconomic backgrounds (Myers, 1995). For these individuals, their lowered sense of self-reliance is reflected in poor self-esteem; they may use self-defeatist and self-handicapping strategies, which further contribute to a negative self-fulfilling prophecy. Finally, a high external locus of control for individuals with hearing loss, particularly adolescents, often results in learned helplessness, depression, and suicidal behavior (Critchfield, Morrison, & Quinn, 1987).

Health Care

For individuals with hearing loss who seek mental health counseling, there are several current barriers to treatment. Clients with hearing loss must sometimes pay exorbitant amounts of money for the evaluation and provision of appropriate mental health services by a qualified psychiatrist (Critchfield, 2002). Additionally, mental health professionals are typically unprepared to meet the needs of clients with hearing loss. Communication barriers and access to interpreter services are also a major concern for individuals with hearing loss who seek psychotherapy. In consideration of these barriers, persons with hearing loss are therefore less likely to seek and be able to afford mental health counseling.

The average lifetime cost for each individual with hearing loss is estimated to be $417,000 (National Center on Birth Defects and Developmental Disabilities, 2004). Individuals may not have the option of pursuing second opinions by qualified specialists because of insurance coverage restrictions and limitations of specialist availability and locality. Depending upon the quality and scope of individual medical insurance, coverage for various specialist services may be restricted (Garber, 2002). Reimbursement rates are particularly low for Medicare and Medicaid recipients and are often insufficient to cover the costs of audiologists’ services (Garber, 2002). Sur-
prisingly, hearing aids are not covered under Medicare, even though more than one third of the nation’s older population has significant hearing impairment by age 65 (Garber, 2002; U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2007).

Education

According to NAD (2003), “normal adjustment, cultural, language, and communication issues are often mistaken for developmental delays, mental illness, or mental retardation” (para. 6) when working with individuals with hearing loss. Misdiagnoses and misunderstanding among professional staff in educational and mental health care systems are unfortunately all too common in the treatment of individuals with hearing loss; clients with hearing loss are often labeled by mental health professionals as low-functioning with minimal language skills, disabled, or handicapped (Sussman & Brauer, 1999). All of these circumstances create sizable gaps in learning, communication, and skills acquisition for children with hearing loss.

Within the public school system, students with hearing loss may opt to learn via inclusion, special education, or supportive services. Students with hearing loss must have both a significant hearing impairment and qualify for special education in order to receive related services such as speech therapy, social work, and counseling (Individuals With Disabilities Education Act Amendments of 1997). Individuals with hearing loss are often socially isolated and have difficulty communicating with hearing persons, particularly for students participating in special education programs in school systems where special education classes are held separately. In addition, students with hearing loss may have multiple disabilities, emotional difficulties, and behavior problems that educational systems are unprepared to address. Students with hearing loss are also in need of supplemental educational services, which include career exploration, independent living skills, communication skills, and social skills, in order to better prepare for the workforce. School counselors may not have the time or specific training to assist students with hearing loss with skills acquisition.

Weighing the benefits and costs of alternatives to public school education is a difficult decision-making process for most families. All states provide appropriate educational services at schools for students who are deaf. However, state schools for students who are deaf may be located far from home, and parents may be reluctant to send their children to live at residential schools (Hands & Voices, 2005). A remote living arrangement may further alienate family members and friends from the child with hearing loss. Second, youth who are hard of hearing or who have mild hearing loss may not identify themselves as deaf and may be uncomfortable in a setting exclusively for individuals who are deaf.

Literacy

In 2002, approximately 69.4% of all students with hearing loss in the United States graduated with official high school diplomas (Bradshaw, 2002). However, the average reading level of high school graduates who are deaf is at a third- or fourth-grade level (Paul, 1998, 2001). According to several statistical studies, 17- and 18-year-old students who are deaf read, on the average, at an equivalent to fourth-grade level (Gallaudet Research Institute, 1996; Hardwell Byrd, 2004; Holt, Traxler, & Thomas, 1997). These statistics may be attributed to delayed learning caused by communication barriers; a shortage of early intervention programs; inadequate teacher preparation; poor family planning and communication; and an emphasis on phonetical instruction, rather than whole language acquisition, in addition to the psychosocial factors mentioned earlier.

Students with hearing loss typically have difficulty on the English reading, writing, and vocabulary recognition sections of high school assessment tests and standardized achievement tests (Hardwell Byrd, 2004). Students who use American Sign Language (ASL) may have difficulty translating signs into English vocabulary, or they may be unfamiliar with the connotations of certain words. Students who are born deaf or who experience early hearing loss usually exhibit symptoms of delayed learning and delayed exposure to the English language, which places them at an unfair disadvantage when it comes to testing. Unfortunately, although students with hearing loss are provided with specialized instruction according to state and federal laws, they are often denied individualized testing accommodations. The majority of state education systems, including schools for students who are deaf, do not allow for the use of interpreters, modified tests, or other special testing accommodations for students who are deaf and hard of hearing (Hardwell Byrd, 2004; Paul, 1998, 2001). As a result of educational and communication barriers, many individuals with hearing loss are functionally illiterate, unable to hold any type of employment requiring secondary reading comprehension and writing skills.

Employment

Barriers to employment for individuals with hearing loss include a lack of related experience; a lack of required skills and training; a lack of supervisor knowledge of suitable accommodations; negative attitudes and uninformed stereotypes; and costs of appropriate accommodations, supervision, and training for employees with disabilities (Loprest & Maag, 2001). Employees with hearing loss may not know how to locate resources or may be ashamed to ask for assistance. Adults with progressive hearing loss and occupational hearing loss are also at increased risk for occupational and social failure because school resources and educational interventions are often unavailable to them. Approximately 2% of the total population that is deaf in the United States is unemployed, and approximately 54% of the total population that is deaf is not in the labor force (Ries, 1994). Of those individuals who are deaf who do work, 29% listed their occupation as professional and managerial, 34% listed it as sales, service,
and administrative support, and 37% listed it as other (Ries, 1994). A disproportionate number of employees who are deaf work in job categories such as trade laborers and manufacturing industries and are far less represented in professional, technical, managerial, and sales and service industries when compared with the hearing population in the United States (Danek & McCrone, 1989).

Occupational hearing loss is the most common occupational disease in the United States (National Institute for Occupational Safety and Health, 1996). More than 30 million workers are exposed to hazardous noise that leads to social, emotional, financial, and medical problems (National Institute for Occupational Safety and Health, 1996). According to the National Center on Birth Defects and Developmental Disabilities (2004), 63% of the lifetime costs associated with hearing loss include the value of lost wages due to the inability to work or employment limitations. In the past, vocational rehabilitation services offered welcome relief to clients with hearing loss seeking job assistance and skills development. Vocational rehabilitation counselors are trained and experienced in serving the needs and promoting the interests of persons with hearing loss and have access to a wide variety of specialized resources and support services (Myers, 1995). State coordinators work with vocational rehabilitation offices to provide specialized services for clients with hearing loss, including job training, vocational placement, assistive technology, and counseling.

However, hearing loss does not automatically qualify individuals for vocational rehabilitation services. Vocational rehabilitation counselors currently use a financial needs test to determine eligibility for basic vocational rehabilitation services (National Rehabilitation Association, 1998; Wright, 1989). Because of limited financial means, some states use an order of selection based on severity of disability, which means that clients with the most significant disability are provided services first (National Rehabilitation Association, 1998). Limited employment opportunities result in widespread joblessness, social isolation, unproductivity, and lowered sense of self-efficacy (Hindley & Kitson, 2000).

Communication

Within the deaf community, there are divergent ideas on best practices in communication modalities. Schools for students who are deaf teach different means of communication: auditory-verbal, ASL, manual coded English, cued speech, lip reading, and total communication, for example (The Children’s Hospital of Philadelphia, Deafness and Family Communication Center, n.d.). Although it may be beneficial to have so many options, an abundance of choices may also cause students with hearing loss and their families to feel overwhelmed and frustrated. For example, providers often refer or recommend parents of young children with hearing loss to an early intervention program and encourage parents to decide on a specific communication modality. Choosing an educational program and deciding on a means of communication that will best serve their child can be an overwhelming task for families. A child who is deaf attending an in-state school for students who are deaf may learn different modalities of sign language and cued speech, but his or her parents may be unfamiliar with these modes of communication.

Communication options may be more limited for individuals who are late deafened and who have since transitioned out of school, and the choices they do have may seem bewildering. For example, an individual who experiences progressive or occupational hearing loss may begin to misunderstand, misinterpret, or simply miss fractions of conversations, or need words repeated. Individuals with hearing loss who have limited English proficiency are especially at risk for communication problems. Community and family members may be unable or, in some cases, unwilling to communicate with the individual with hearing loss in English-based sign language. It requires an enormous coordinated effort to implement the use of sign language or alternative modes of communication successfully within an individual’s school, work, and residential settings.

In conclusion, individuals with hearing loss are at risk for social, educational, and occupational failure. Persons with hearing loss are prone to depression, suicidal ideation, substance abuse, risky behaviors, and mental health diagnoses (Critchfield et al., 1987; Larew, 1995). These problems may be attributed to high levels of stress, societal discrimination, a lack of resources and a supportive network, and maladaptive coping mechanisms (Guthmann, Sandberg, & Dickinson, 1999). By the time the majority of clients with hearing loss are referred for mental health services, they have begun to exhibit negative behavioral symptoms, poor coping mechanisms, subpar academic performance, diminished social skills, and a decline in overall mental health (Larew, 1995; Myers, 1995). Clients with hearing loss are in dire need of appropriate direction and professional support.

Counselor Competency

Unfortunately, there are few qualified psychiatrists, psychologists, mental health therapists, and employment counselors who are both knowledgeable of deaf culture and fluent in their clients’ preferred modalities of communication (Critchfield, 2002). The majority of professional counselor training programs rarely include mental health issues related to hearing loss. The exams, skills, and experience required by state licensure boards and certification agencies often neglect to include topics relevant to clients with hearing loss (Stewart, 1987). Similarly, continuing education workshops and seminars offered by protective and advocacy organizations are usually unconcerned and uninformed about mental health issues and deafness; even fewer members of the justice system are familiar with issues of ethics and hearing loss (Stewart, 1987). This section discusses opportunities for mental health counselors who may lack the necessary experience and train-
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Mental health counselors and other mental health professionals must become advocates for their clients’ civil rights and be prepared to assume nontraditional roles. This means understanding and advocating for clients’ civil rights under protective laws such as the Individuals With Disabilities Education Act of 1990, the Americans With Disabilities Act of 1990, and the Rehabilitation Act of 1973 (NAD, 2003; National Rehabilitation Association, 1998). All health care providers, regardless of the number of employees, have a duty to provide effective communication, using auxiliary aids and services that ensure equally effective communication (NAD, 2003). Appropriate aids and services include qualified interpreters, assistive listening devices, note takers, written materials, media captioning, and telecommunications devices (Americans With Disabilities Act of 1990; NAD, 2003). In addition, health care providers cannot charge their clients for the costs of these provisions directly or via the clients’ insurance carrier (Americans With Disabilities Act of 1990; NAD, 2003).

For clients who communicate in ASL, their counselors’ sign language fluency is as important as the counselors’ other therapeutic skills (Steinberg, Sullivan, & Loew, 1998; Sussman & Brauer, 1999). Although many counseling professionals may have some familiarity with mental health issues related to deafness, and some may possess intermediary skills in communicating in ASL, this does not translate to professional expertise. An understanding of ASL or other languages at a functionary level is not the equivalent of being able to interpret that language in a clinical setting. Mental health professionals must consider and serve the best interests of their clients by having an interpreter present, if needed. Interpreters may be fluent in ASL, Signed English, cued speech, and oralism, depending on the needs and communication preferences of their clients. Qualified interpreters should be able to adequately explain any medical terminology and occupational titles during professional consultations. Family members and friends are discouraged from serving as interpreters because of potential conflicts caused by confidentiality violations and the assumption of dual roles (NAD, 2003).

The use of interpreters in counseling while also protecting client confidentiality is an important issue for mental health counselors working with clients with hearing loss. The deaf community, although nationally large, is regionally small, and clients may be afraid that if their problems are discussed in front of the local interpreter, their confidentiality may be jeopardized, particularly if the interpreter assumes multiple roles in the community (Gutman, 2002). The juxtaposition of counselor, interpreter, and client has its own problems: Counselors must be able to trust that their interpreters are accurately conveying messages to and from their clients, without interference of personal judgment or interpretation. It is advisable that counselors using the services of interpreters meet and discuss any possible barriers to communication beforehand, as well as review confidentiality and structure of the session.

Counselor Self-Awareness

Becoming a multiculturally competent counselor entails self-analysis and self-awareness. Mental health counselors must be aware of their own ignorance, countertransference, and potential biases due to limited experience and a lack of knowledge when counseling clients with hearing loss. Before treating clients with hearing loss, mental health counselors first need to reflect on their own attitudes and perspectives of deafness. Counselors who perceive hearing loss as a detrimental disability will likely reinforce their clients’ poor self-esteem and low self-efficacy. Counselors and other professionals serving the population that is deaf may need to revise their conceptualization of deafness as a disability.

In accordance with Standards A.11.b. and C.2.a. of the ACA Code of Ethics (American Counseling Association [ACA], 2005), counselors must also recognize their limitations of expertise and refer clients with hearing loss when beneficial to more qualified clinicians. Counseling professionals are also recommended to seek out additional training, experience, and supervision prior to and throughout treatment when choosing to accept clients with hearing loss (ACA, 2005, Standards C.2.b., C.2.c., C.2.d., and C.2.f.). Appropriate training involves understanding and knowledge of developmental, historical, educational, social, cultural, linguistic, vocational, economic, and demographic aspects of deafness (Sussman & Brauer, 1999). Relevant experience requires practice with specific principles, practices, and approaches in psychotherapy; psychological evaluation; and diagnosis with clients who are deaf, preferably supervised by a psychotherapist or therapist who is deaf experienced working with clients who are deaf (Sussman & Brauer, 1999).

Communication competencies also include increased awareness of clients’ nonverbal cues and body language, such as pantomime, gesture, and facial expression (Sussman & Brauer, 1999). Mental health counselors may have to modify their interpersonal styles in order to better accommodate the needs of their clients with hearing loss; for example, it may be necessary to change lighting or arrange seating so that they are visible to their clients at all times. As counselors, we also need to be aware of our personal communication style: Are we shouting because our client is hard of hearing? Are we exaggerating every word we say? Are we speaking slower than usual? Are we pretending to understand what our client is saying so that we do not offend? Mental health professionals who lack experience and knowledge working with clients with hearing loss must be careful to avoid propagating communication barriers.

Use of Interpreters

Mental health counselors and other mental health professionals must become advocates for their clients’ civil rights and be prepared to assume nontraditional roles. This means understanding and advocating for clients’ civil rights under protective laws such
general influence the outcome of therapy (Sussman & Brauer, 1999). Because of their disenfranchisement and marginalization, clients with hearing loss are treated as minority status citizens (Gutman, 2002). Persons with disabilities are more likely to have a common sense of identity with other people with disabilities; 56% affirm that they do (National Organization on Disability, 2004). However, clients with hearing loss may consider themselves as members of the deaf community and not identify themselves as disabled. There is a growing movement to recognize deafness as a rich, unique culture; many individuals with hearing loss are now referring to themselves as deaf, indicating membership of a distinct culture (Gutman, 2002; Shapiro, 1993). Whether clients consider themselves as disabled and what negative and positive messages clients receive from the counselor concerning their abilities are crucial issues to work through in therapy. It is recommended that all mental health counselors treating clients with hearing loss use culturally specific counseling skills in psychotherapy, while still operating from an emic perspective emphasizing awareness of client diversity.

Therapeutic Models

A wide variety of psychoanalytic approaches have been used successfully with clients with hearing loss, including humanistic and Rogerian, Adlerian, reality therapy, cognitive therapy, and rational-emotive therapy (Edelwich & Arre, 1987; Sussman & Brauer, 1999). In the past, treatment approaches were paternalistic and directive; the counselor established the agenda, goals, and outcomes of treatment (Gutman, 2002). This model tended to stunt the client’s independence and inhibit participation in treatment (Gutman, 2002).

Regardless of theoretical orientation, competent mental health counselors working with clients with hearing loss work to depathologize deafness and concentrate on their clients’ strengths and assets. Strengths-based counseling always focuses on ability, not disability. Individuals with hearing loss learn to refuse society’s attempts to handicap them through limitations, restrictions, and discrimination (Sussman & Brauer, 1999). Wellness models and positive psychology approaches serve to actualize client growth and adjustment, thus promoting competency and potential and enhancing quality of life. It is no surprise that individuals with hearing loss who experience independence and community integration tend to have positive educational and economic outcomes. Clients with hearing loss who have high self-esteem and an internal locus of control have higher earnings levels and enter more competitive employment on average (Schmidt-Davis, Kay, & Hayward, 1999).

A client-centered therapeutic approach is beneficial in that it focuses on the client’s interests, strengths, talents, and abilities rather than the client’s perceived disadvantages and limitations of hearing loss. The question to ask clients with hearing loss is, “What do you want to do?” rather than “What can you do?” When forming hypotheses in treatment planning with clients with hearing loss, it is important to discuss the client’s locus of control. What, if any, is the perceived disability? Who or what contributes to the client’s feelings of disempowerment? Linking awareness and control can help the client with hearing loss overcome obstacles and make informed decisions that promote self-efficacy (Hindley & Kitson, 2000). Power analysis, assertiveness training, and esteem building are useful techniques to empower clients with hearing loss. For example, client and counselor can role-play a situation in which the client has to assert his or her civil rights or ask for an advocate.

Wax (1999) advocated the use of developmental-existential-affirmative-formulative therapy with clients with hearing loss, a culturally affirmative personal psychology. With this model, client self-awareness and self-exploration are emphasized; counselor and client together develop appropriate behavioral episode schemas related to the individual’s multiple identities and work toward self-integration. Clients with hearing loss strive to make meaning of what it means to be deaf in a hearing world and adjust their cognitions and behaviors affirmatively, while simultaneously navigating their other cultural identities, such as race, age, and gender roles. This technique blends cognitive, culturally specific, feminist, and humanistic approaches tailored specifically to the needs and commonalities of clients who are deaf from an ecological perspective.

Levine’s (as cited in Hindley & Kitson, 2000) case history guide discusses the importance of gathering identifying data during the initial stage of counseling. Using this model with clients with hearing loss, mental health counselors ask their clients about the history of family deafness and onset of deafness; developmental history and milestones; family background; medical health status and auditory history; educational background; psychosocial profile; vocational aptitudes, interests, and skills; social participation; and roles (Hindley & Kitson, 2000). The client’s overall self-concept, including his or her attitudes toward deafness, deaf culture, and hearing society, is critical to the counseling process (Hindley & Kitson, 2000). In addition, counselors using this model ask their clients for an honest self-assessment of assets and liabilities before and during treatment planning.

Farrugia (1985) depicted an ideal initial session with clients with hearing loss to incorporate an Adlerian lifestyle assessment, including client case history, psychological interview, clinical impressions of expressive and symptomatic behavior, testing, description of family constellation, early recollections, and group interactional processes. Counselors working with clients with hearing loss use emerging lifestyle themes as a framework upon which to build treatment planning goals and a career plan (Farrugia, 1985). With clinical assistance, clients relate their lifestyles to work goals. Counselors help their clients list obstacles and strategies, identify subjective and objective resources, and formulate and initiate action plans (Farrugia, 1985). The role of the counselor using this
approach is to provide encouragement and support and serve as a resource for clients and their families.

**Therapeutic Interventions**

Mental health counselors are, of course, specifically trained to assist their clients in leading productive lives in a variety of ways. Counselors can help clients acquire and reinforce job readiness skills by providing role-play exercises, psychoeducation, and opportunities for exploration and growth. One way counselors can initiate the process of goal setting is to aid clients in identifying their preferred methods of communication, locating community resources, and developing independent living skills. For example, educative information regarding self-care and self-presentation may be necessary and often beneficial (Burgess, Shaw, Larew, Ouellette, & Long, 2000; Larew, 1995).

The following issues may be useful to explore in counseling when working clients with hearing loss: hygiene, health care, and medical concerns; use of community resources; public safety; transportation; community awareness; civil rights; money management; problem solving; sexuality and the transmission of sexually transmitted diseases; and family planning and parenting skills (Larew, 1995). Counselors may also facilitate instruction in survival reading skills; interpersonal, social, and communication skills; stress management, relaxation training, and coping skills; and refusal skills and assertiveness training (Larew, 1995). Facilitating career development skills, such as job searching strategies, résumé building, and interviewing techniques, is also especially relevant to this population (Burgess et al., 2000).

Counselors can assist clients with hearing loss prepare a summary of their needs and strengths and make recommendations to employers regarding reasonable accommodations and suggested resources. In order to act as advocates for their clients, mental health counselors first need to review and understand the Americans With Disabilities Act of 1990, particularly Title I, which addresses employer responsibilities for providing reasonable accommodations for employees with hearing loss (Americans With Disabilities Act of 1990; National Center for Law and Deafness, 1992). Reasonable accommodations include job restructuring, equipment and training modules modification, telecommunication devices (teletypewriters and telecommunications devices for the deaf), amplified telephones, visual alarms, assistive listening devices, and qualified sign language interpreter services (Americans With Disabilities Act of 1990). Effective communication and accessibility extends to all aspects of employment, including job training, benefits, and company events and programs.

Many clients with hearing loss may not have had opportunities to explore their vocational interests and abilities. Interest inventories and psychological tests designed to promote self-awareness of work styles, learning preferences, interactional modes, and personality types are often helpful. Mental health counselors must be cognizant, however, that the majority of psychological tests, vocational aptitude tests, and career interest inventories have not been normed with populations who are deaf and are therefore not empirically standardized for use with clients with hearing loss (Stewart, 1987). In addition, major neuropsychological assessment tests, such as the Wechsler Adult Intelligence Scale–Revised (Wechsler, 1981), cannot be reliably and validly used in their entirety with individuals who are deaf (Stewart, 1987). Counselors should exercise caution when interpreting such tests and use any results as tentative groundwork for further exploration in future sessions.

Watson (1985) described specific strategies for career counseling with clients with hearing loss. First, counselor and client assess the client’s job readiness, life skills, interests, and prospects in relation to job possibilities. This process can be facilitated via cooperative vocational exploration and vocational rehabilitation counseling services. Reexamination of existing job placement practices and client advocacy may be necessary in some instances. Counselor and client then jointly identify support services and resources needed to maintain employment (Watson, 1985). Identification and development of personal job-related assets via testing and interest inventories are beneficial in this stage. Last, clients with hearing loss practice interviewing and are introduced to work adjustment counseling; counselors may instruct or model related skills. Postemployment interventions to improve clients’ overall job satisfaction, including knowledge, attitudes, and interpersonal communication skills, may occur via assertiveness training, behavior management, and job coaching (Watson, 1985). Counselors may also initiate contact with clients’ employers (with appropriate consent) to evaluate job satisfactoriness and conduct follow-up group counseling.

Mental health counselors should also make every effort to refer clients with hearing loss to vocational rehabilitation counseling services. The overall goal of vocational rehabilitation is to optimize clients’ levels of functioning; for clients with hearing loss, an additional psychosocial task is to enhance their opportunities for success in a hearing world (Gutman, 2002). Akin to wellness models, the rehabilitation approach evaluates personal and environmental barriers to clients’ specific goals and takes necessary action steps to reduce or eliminate these obstacles.

Vocational rehabilitation counselors ready individuals with hearing loss for independent living and attempt to equip them with survival skills that will aid in future decision making and effective problem solving (Duffy, 1999). According to the Longitudinal Study of the Vocational Rehabilitation Services Program (Hayward & Schmidt-Davis, 1999), overall, 78.4% of consumers who left vocational rehabilitation with an employment outcome entered competitive employment. Additionally, more than two thirds of transitional youth with hearing loss using vocational rehabilitation services received assistance with job placement, vocational training, and support for education (Hayward & Schmidt-Davis, 2000). Every state has its own centralized office of vocational rehabilitation and
local branches (Job Accommodation Network, n.d.; a listing of vocational rehabilitation state offices can be accessed online at http://www.jan.wvu.edu/sbses/vocrehab.htm).

Systemic Interventions

Regardless of theoretical orientation, all counselors are called upon to foster cultural awareness and affirm the cultural pride of their clients with hearing loss. This includes educating themselves, their clients, and their clients’ families and employers about deaf culture. Mental health counselors will need to coordinate services between schools, specialists, employers, and caretakers. If possible, counselors should use the services of wraparound programs, usually coordinated by schools and county and state behavioral health agencies. Ideally, counselors serving clients with hearing loss will facilitate as liaisons between mental health services, vocational rehabilitation, legal services, medical treatment, educational providers, and the deaf community (Myers, 1995).

A systemic approach is much more effectual in counseling clients with hearing loss because it engages the client’s family and analyzes environmental influences that may be negatively and positively affecting the client’s well-being and socioeconomic, educational, and occupational opportunities. Children with hearing loss residing in hearing families are particularly at risk for isolation and ostracism; counseling the entire family in a united effort to improve the child’s functioning and strengthen the family structure is highly desirable. Counselors should not hesitate to welcome extended family members, close friends, and other caretakers into the therapeutic circle.

Strains on family finances and time often negatively affect the individual with hearing loss, who may feel guilty for burdening others. Parents often also internalize shame and guilt because they believe that they may have caused or contributed to their children’s hearing loss and feel unequipped to deal with their children’s social and emotional needs (Heller & Watson, 1985). Long (1985) stated that an effective counseling approach when serving clients with hearing loss places an emphasis on family dynamics, behavior, and modes of communication. This assessment examines familial perceptions of deafness, coping skills, communication barriers, stress, and sibling relationships (Long, 1985).

Last, for clients with hearing loss struggling with drug and alcohol abuse, a systemic approach is also recommended, because addiction is a family disease. Approximately one third of all individuals who are deaf with mental health problems have dual diagnoses, particularly problematic drug and alcohol use (Hindley & Kitson, 2000). Given the prevalence of addictions problems and heightened risk factors for this population, mental health counselors are advised to combine systemic, group, and individual treatment modalities when counseling clients with hearing loss who have co-occurring disorders.

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, for example, uses a 12-step recovery treatment approach to rehabilitate clients; 75% of admitted clients with hearing loss to the Minnesota Program have dual diagnoses (Guthmann et al., 1999). What differentiates this model from other programs is its emphasis on vocational rehabilitation and basic employment skills, in addition to accessible language, detoxification, self-help support groups, educational services, and occupational and recreational therapy (Guthmann et al., 1999). Mental health professionals employed by the Minnesota Program are specifically trained to serve the needs of individuals who are deaf and to provide comprehensive counseling and aftercare services (Guthmann et al., 1999). The success rate of the Minnesota Program is comparable with the success rate of similar 12-step programs for hearing individuals (Guthmann et al., 1999).

Conclusion

In conclusion, counseling clients with hearing loss poses special challenges to mental health professionals, but change is long overdue for this underserved population. Mental health counselors need to reexamine their competencies, biases, and knowledge when working with this population. Counselors should also expect to step outside their usual capacity as therapist and assume nontraditional roles as advocate and educator in order to coordinate a systemic effort toward change for their clients. Counselors should also be prepared to explore and use a variety of therapeutic approaches that reflect the rich diversity of individuals with hearing loss.

References


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