Audiologic Counseling and Work-Readiness Program for Deaf and Hard of Hearing Young Adults

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A hospital-based audiologic counseling and work-readiness program can meet the prevocational needs and increase the employability of deaf and hard of hearing young adults by addressing communicative, psychosocial, and vocational issues. This paper describes (a) the prevocational needs of deaf and hard of hearing young adults; (b) the rationale, goals, and services of a comprehensive audiologic counseling and work-readiness program; (c) the stages of the counseling model; (d) an individualized transition plan; (e) demographic and psychometric characteristics for those clients enrolled in the program; and (f) for those clients who completed the program, the status of employment outcome one year after program termination.

The transition from adolescence to adulthood can be a stressful time for deaf and hard of hearing young adults in selecting and preparing for a career. Factors that affect the successful transition from high school to the work place include poor communication skills, psychosocial issues affecting self image and self esteem, lack of work-readiness skills, limited vocational decision-making abilities, unrealistic parental expectations, and lack of awareness of community resources for vocational preparation and placement (Roberts, Bryant, & Wharton, 1990). Prevocational education and counseling with deaf and hard of hearing young adults are prerequisites for successful career selection, preparation, and growth.

Although historically it has been reported that deaf persons have been underemployed rather than unemployed (Moores, 1969; Nash & Castle, 1980; Schein & Delk, 1974), Phillippe and Auvenshine (1985) concluded that they are more likely to be both unemployed and underemployed compared to their hearing

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peers. They further noted that employment difficulties can be grouped into three areas: (a) poor education and social adjustment, (b) employer stereotypes and feelings, and (c) ineffective counseling to counteract the stereotypes and lack of information of the deaf. Nash and Castle (1980) reported that increasing technological change in conjunction with unique academic and psychosocial problems could result in new and more severe career problems for deaf adults in the future. The need for improved decision-making skills (DiFrancesca, 1978; Gellman & Eisenberg, 1979), more vocational information (Lerman, 1976; Phillippe & Auvenshine, 1985), less dependence on others (Roy, 1962), greater experiential learning (Jacobs, 1980; Mindel & Vernon, 1971; Sligar & Culpepper, 1979) and improved development of interests (Farrugia, 1982; Lerman, 1976) are factors which may influence the vocational development of deaf individuals. Thus, personal, social, communication, and technical competencies are necessary for deaf and hard of hearing persons to achieve vocational success in the changing job market.

The American Speech-Language-Hearing Association (ASHA) Committee on Rehabilitative Audiology (1974) proposed that an organized program of counseling be included as an integral part of a comprehensive audiologic habilitation plan. Recommended objectives should include the following: (a) enhancement of the individual's welfare, (b) assistance in the resolution of pertinent problems, (c) stimulation and motivation to achieve, and (d) improvement of self-concept and social relationships. Further, audiologists should have knowledge of counseling techniques necessary to manage deaf and hard of hearing individuals and their families regarding psychosocial, educational-vocational, communication, and economic problems associated with hearing loss (ASHA Committee on Rehabilitative Audiology, 1980; McCarthy, Culpepper, & Lucks, 1986). Hearing healthcare providers may have important insights into the communication problems and subsequent adjustment difficulties of deaf and hard of hearing persons (Erdman, Crowley, & Gillespie, 1984). Audiologic counseling should be designed to assist deaf and hard of hearing individuals realize their communication, social-adjustment, and vocational-placement potential.

The purpose of this paper is three-fold. First is to describe the prevocational needs of deaf and hard of hearing young adults in the Fresno Metropolitan area. Second is to discuss the rationale, objectives, goals, and services of a comprehensive hospital-based audiologic counseling and work-readiness program. Third is to present demographic and psychometric characteristics for those clients who were enrolled in the program; and for those clients who completed the program, present employment outcome data one year after program termination.

AUDIOLOGIC COUNSELING AND WORK-READINESS PROGRAM

Community Needs Survey

A survey was conducted to determine the prevocational needs of deaf and hard of hearing young adults in the Fresno Metropolitan area, and the resources

available to address them. Parents of deaf and hard of hearing adolescents, counselors, and administrators from the California State Department of Rehabilitation, representatives from community advocacy and support groups for the deaf and hard of hearing, and teachers and administrators from Fresno Unified School District's oral/aural and total communication special day classes were interviewed. Following is a summary of six areas of need that affect successful vocational placement and retention as identified by those surveyed (Roberts, 1989, 1991; Roberts & Bryant, 1988a; Roberts et al., 1990; Roberts & Wharton, 1988).

Communication skills. Limited receptive and expressive verbal and manual communication skills were identified as a major problem area with this population. For example, deaf and hard of hearing adolescents have limited ability to communicate with employers, supervisors, parents, and peers. In addition, language and basic educational skills are often fourth grade level and below.

Psychosocial skills. Another area of need that the respondents identified for this population was psychosocial skills in the work setting. Examples cited were that young adults may demonstrate a lack of self-confidence, have poor self-image, may not accept responsibility, experience low self-esteem, and may be sensitive to criticism. It is important to emphasize that these results were the perceptions of professionals which were unsubstantiated by outside psychological evaluation.

Work-readiness skills. Young adults were also reported to have limited experience and knowledge of the work ethic. That is, some young adults may have little understanding of vocational concepts (e.g., speed, quality, and consistency of performance, punctuality, attendance, and the relationship between production and earnings). Some also experience difficulty following and adhering to a supervisor's instructions.

Vocational-decision making skills. Respondents indicated that there was limited understanding of the factors involved in selecting, preparing for, and retaining a job. Examples included the adolescents' understanding of their own skills, aptitudes, and abilities, and their application to available options for employment.

Parental expectations. Many parents were reported to have limited information about their adolescent's hearing loss and unrealistic perceptions of their adolescent's vocational, social, and educational capabilities. For example, some parents expected their adolescent to go to college without adequate capabilities or training; others had low achievement plans for capable teenagers.

Awareness of community resources. Survey respondents also reported that some parents and young adults lacked adequate information regarding advocacy and support groups, state and community agencies, sign language interpreting services, public assistance, and laws advocating the rights of deaf and hard of hearing persons. For instance, parents and young adults are often unaware of the vocational assistance provided by the California State Department of Rehabilitation, their rights to sign language interpreting services in various medical,

educational, and vocational settings, role models in the deaf community, advocacy and support groups for the deaf and hard of hearing, and social security benefits.

During the time of the survey, there were approximately 300 deaf and hard of hearing youth, ages 2-21 years, in the Fresno Metropolitan area. Of these, 60 students, ages 14-21 years, were enrolled in oral/aural and total communication special day classes in the Fresno Unified School District. Many of these young adults were eligible for and received public assistance. After completing high school, they could either prepare for and obtain employment or continue to receive public assistance. Since the deaf and hard of hearing clientele was the most costly caseload maintained by the California State Department of Rehabilitation (Shipley, 1988), a primary objective was to assist them to become self sufficient through employment.

The findings of the community needs survey were consistent with the results of others (Gellman & Eisenberg, 1979; Jacobs, 1980; Nash & Castle, 1980; Phillippe & Auvenshine, 1985), and indicated the need for the establishment of an audiologic counseling and work-readiness program to counsel and educate families, and prepare deaf and hard of hearing young adults to become self sufficient through employment. Thus, the California State Department of Rehabilitation funded the establishment of a hospital-based audiologic counseling and work-readiness program in the Department of Speech-Language Pathology and Audiology at Valley Children's Hospital.

Program Eligibility

Clients referred to Valley Children's Hospital's Audiologic Counseling and Work-Readiness Program had to meet the following criteria: (a) be diagnosed as having a bilateral hearing loss in the mild-to-profound range, (b) be between the ages of 14 and 22 years old, (c) demonstrate a performance intelligence level between borderline (i.e., low normal) and superior (i.e., above normal), and (d) be enrolled or eligible for the California State Department of Rehabilitation services. Although adolescents must be 16 years old in order to be eligible for California State Department of Rehabilitation services, 14 and 15 year old adolescents were referred on a "pre-rehab" basis. That is, they were referred to the program to address prevocational issues and prepare them for vocational rehabilitation placement services.

Stages of the Counseling Program

Hansen, Stevic, and Warner (1982) described counseling as a "process," a series of stages through which the counselor and client move toward resolution of whatever precipitated the need for seeking assistance. In the context of the audiologic counseling and work-readiness program, "assistance" was prevocational counseling and preparation for vocational rehabilitation placement services. The model that was used in the hospital-based program consisted of five

stages: (a) assessment, (b) goal setting, (c) determination of intervention strategies, (d) evaluation of intervention effectiveness, and (e) termination and follow-up (Roberts, 1989, 1991; Roberts & Bryant, 1988a; Roberts et al., 1990; Roberts & Wharton, 1988). The next section describes the stages of the audiologic counseling and work-readiness program.

Assessment. Roberts and Bryant (1988b) reported that the counseling process begins with: (a) establishment of the purpose of the client's visit; (b) description of the client's need for seeking assistance; (c) listing the potential reasons which prevent the client from realizing optimal communication, social adjustment, and vocational placement; (d) determining the client's desired outcomes of counseling; and (e) assessment of the client's motivation. Empathy, genuineness, and unconditional positive regard were established in this first stage as these three conditions were essential for facilitating rapport and thus, an effective counseling relationship with deaf and hard of hearing individuals (Chermack, 1979; Erdman et al., 1984; Kodman, 1966; Luterman, 1976; Pollack, 1978; Roberts & Bouchard, 1989; Wylde, 1987).

Since one of the program goals was to address prevocational counseling needs, an assessment was conducted that consisted of an intake interview and diagnostic evaluation. The purpose was to determine the client's type and severity of hearing loss, amplification needs, functional communication skills, and attitudes and goals towards choosing, preparing for, and maintaining a job. Whenever possible, the intake interview included the immediate family to obtain each member's perception of how the client's hearing loss impacted on functional communication skills, educational achievement, social interaction skills, independent living skills, and vocational success. Seeking insight into the dynamics of the client's and family's communication assisted in developing an Individual Aural Rehabilitative Plan (IARP). Observing the family as a whole provided the audiologist an opportunity to view how the members interacted with each other, how they communicated with the client, and what alliances were formed that may have been related to the client's need for assistance. For example, one client who was motivated to find employment was not supported initially by his parents, because they relied upon his monthly public assistance to help pay for the family's living expenses. During the interview, they acknowledged the need to support employment and not rely on their young adult's public assistance for family expenses.

The diagnostic assessment consisted of evaluating: (a) the type and severity of hearing loss using puretone and speech threshold testing, (b) hearing aid function using both electroacoustic and soundfield functional gain measures, (c) speech recognition skills in the auditory-alone mode progressively increasing the complexity of the speech material from digits to CID everyday sentence, (d) lipreading skills in the visual-alone and auditory-visual combined modes, and (e) functional communication skills during the intake interview. A certified sign language interpreter assisted in evaluating the functional communication skills of those clients who used American Sign Language as their primary mode of

communication.

Goal setting. During the second stage, the client and audiologist established a functional counseling relationship. The client's and parent's past attempts to resolve issues associated with the hearing loss were identified. Most clients did not understand how to build a bridge between the problem situation and the desired outcome. In order to accomplish this, goals and outcomes for audiologic counseling were formulated (Roberts, 1987). A contracted treatment plan was used as an integral part of the program and detailed the purpose of the relationship, what and who it involved, and its duration. That is, contracting made known the roles, expectations, and obligations of everyone involved in each client's program (Luterman, 1984). If the client and audiologist could not agree on a mutually-satisfactory contract, the relationship was terminated.

Evaluative information for clients was synthesized to develop specific behavioral objectives to address communicative, psychosocial, and vocational needs. An IARP was developed in cooperation with the department of rehabilitation counselor's individualized written rehabilitation plan (IWRP) and the school district's individualized educational plan (IEP). Specific goals and strategies were also written into an individualized transition plan (ITP) by the rehabilitative audiologist, rehabilitation counselor, teacher, independent living skill's counselor, the client, and parents. The goal of the ITP was successful employment of the young adult.

Determine intervention strategies. The third stage focused on the outcome goals of each client's IARP by addressing the six areas of need identified in the Fresno survey. Services provided at the hospital included individual and group counseling sessions. All clients were scheduled minimally for one 60-minute individual counseling session prior to being enrolled in 90-minute group sessions. Clients with specific prevocational needs not conducive to the homogeneous nature of the group setting were seen individually. Group counseling has been reported to be an effective complement to individual counseling (Shertzer & Stone, 1981; Stewart, 1986). Groups were comprised of between three and seven young adults who were grouped by age, educational background, and primary mode of communication. Group counseling served the function of disseminating information, skill development, decision-making, self-understanding, reality testing, emotional support, and power base to effect change (Lifton, 1972). Some of the topics discussed were (a) work habits and attitudes, (b) factors and capabilities involved in choosing and preparing for a job, (c) factors and capabilities involved in retaining or leaving a job, (d) protocol for procuring a sign language interpreter, (e) feelings associated with one's hearing impairment, (f) feelings associated with the transition from high school to a vocation, and (g) community agencies and self help groups that offer services to deaf and hard of hearing persons. The role of the audiologist was to provide an environment where deaf and hard of hearing young adults engaged in self-disclosure and feedback by expressing their attitudes and feelings. In the group setting, clients helped others accept their assistance, feedback, support, encouragement,

and reinforcement of new behaviors.

Both formal and informal group sessions also provided an environment where parents could meet to discuss various issues and feelings. Formal sessions explored topics such as vocational assistance, independent living skills, sign language interpreting services, role models in the deaf community, and advocacy and support groups for the deaf and hard of hearing. Informal sessions consisted of activities such as socializing in the hospital waiting room while waiting for their sons and daughters who were attending formal counseling sessions.

Counseling techniques that were used with the deaf and hard of hearing young adults were more directive, informational, and counselor-centered. For example, role playing was an effective method of informing, demonstrating, and reinforcing concepts and skills such as effective communication with a supervisor or interviewing for a job with a potential employer. Behavioral modification techniques were also used to reinforce new concepts and skills.

There was also a need for greater patience in counseling this sample of deaf and hard of hearing young adults as compared to hearing clients. Gellman and Eisenberg (1979) have emphasized that the application of counseling principles and methods developed in a hearing world to deaf clients requires expansion of the time dimension.

Cultural value and lifestyle differences, client expectations about the counseling process, stereotyping, effective counseling strategies, motivation to change and achieve mutually-established goals, and scheduling constraints were issues that needed to be considered throughout the program. Approaches were chosen that matched both the personal and cultural background of the client and family. For example, hospital-based interpreters were used to converse with parents in their native language. Although it was preferred that the audiologist be fluent in American Sign Language, the use of a certified sign language interpreter consistently throughout the program was necessary. Further, it was important to note that the audiologist working with deaf and hard of hearing young adults had knowledge of the job market and occupational conditions among the deaf and hard of hearing population.

Assess intervention effectiveness. The fourth stage of the program was to assess change as the result of the aural rehabilitation program. The treatment plan was continually monitored and modified as the needs of the client dictated. Integration of successful outcomes of the IARP with changes in family and peer interactions, vocational readiness skills, vocational decision making, and utilization of community resources was a strategic step in assessing treatment effectiveness.

Termination and follow-up. The fifth stage was to agree upon the time-line for termination of aural rehabilitation services once the goals of the individualized aural habilitation treatment plan had been reached. Acknowledging the client's roles in behavioral change was an essential step in terminating the relationship. Since the client's IARP was only one aspect of the client's transition plan, coordinating and monitoring referrals for the client and family to other professionals

were essential. A plan for clinical follow-up services was developed in order to monitor progress.

Individualized Transition Plan

Clients were enrolled into the program on a continuous basis over a two year period. Aural rehabilitation goals were incorporated into both an IARP and ITP, and accomplished through weekly individual and group aural rehabilitation counseling sessions. The amount of time devoted to accomplishing IARP varied relative to the needs and progress of the client. However, approximately 30 individual and/or group counseling sessions were completed for each client over a six-to-nine month period.

The interagency team was usually convened at the request of the rehabilitation counselor and included the audiologist, teacher, independent living skills specialist, client, and parents. Interagency team meetings were held prior to enrollment in and discharge from the audiologic counseling and work-readiness program. However, any member of the team could arrange for an interagency meeting at any time throughout the program. Periodic staff meetings and phone conversations were made to update progress and evaluate the clients' goals with other professionals involved in the ITP throughout the client's program. Prior to discharge of a client from aural rehabilitation, the goals and outcomes of the entire assessment and therapy plan were reviewed by members of the multidisciplinary team. Referrals were made to other professionals as necessary for further vocational management.

RESULTS OF THE PROGRAM

There were 45 young adults who were referred to the program. Of these, 14 (31%) did not meet the criteria for program enrollment. Of the 31 (69%) clients who were enrolled in the program over the two years, 24 (77%) successfully completed all of the treatment goals of the program. Seven (23%) did not complete the program due to transportation difficulties, poor parental support, and scheduling problems.

Demographic and Psychometric Characteristics

The demographic and psychometric characteristics for the 31 clients enrolled in the program are shown in Table 1. As illustrated, the primary mode of communication, age of enrollment in the program, gender, race, degree of sensorineural hearing loss, grade level, type of educational setting, performance intelligence quotient (IQ), basic educational skill level, and reading level are reported for each client.

It is interesting to note that the performance intelligence quotient (IQ) for the majority of the young adults was within the normal range. However, the basic educational skill level (spelling and arithmetic) ranged between the first and seventh grade level, with the majority of reported scores being at the third and

fourth grade level. In addition, the reading level ranged between the second and fourth grade level, with the majority of clients demonstrating a third to fourth grade reading level. These results are consistent with the report of the President's Commission on Education of the Deaf stating that the status of education for the deaf is unsatisfactory (Chertow & Williams, 1988).

Employment Outcome

There were 24 clients who successfully completed the audiologic counseling and work-readiness program. One year after program termination, five (21%) clients were enrolled in high school. Three of these five students were also working in a fast food restaurant, and all five have been successfully involved in Summer Youth Employment Training Programs (SYEPT) through the Fresno Unified School District's Workability Program. Twelve (50%) clients were high school graduates and employed in either full-time or part-time positions such as motel maintenance, housekeeping, clerktypist, computer data transcriber, homemaker, restaurant dishwasher, and insurance clerk. Three (12%) had been employed in at least one job since the completion of the program and were currently involved in a vocational training program with the department of rehabilitation. Two (8%) were enrolled in Fresno City College. Thus, 22 of the 24 clients were either working in a full-time or part-time position or preparing for a career and enrolled in a college curriculum.

DISCUSSION

One year after program termination, the employment outcome results for those clients who completed the program suggest that a hospital-based audiologic counseling and work-readiness program can meet the vocational-readiness needs and increase the employability of deaf and hard of hearing young adults. Paramount to effective vocational management are aural rehabilitation services that address communicative, psychosocial, and vocational issues. An IARP can be established in conjunction with the rehabilitation counselor's IWRP and the school district's IEP. Strategies for addressing the specific needs of deaf and hard of hearing young adults are incorporated into an ITP developed by a multidisciplinary team consisting of an audiologist, rehabilitation counselor for the deaf, school personnel, and representatives from advocacy and support groups. The cooperative interaction of the team members results in an individualized and focused transition plan for each hearing-impaired client and family, with clearly stated goals, objectives, and strategies.

Another outcome has been an increased community awareness of services available to address the psychosocial, communicative, vocational-readiness, and employment needs of hearing-impaired deaf and hard of hearing young adults. There are four reasons for this heightened community awareness. The first is increased interagency networking among the representatives from the department of rehabilitation, local school systems, and advocacy and support groups for the

Table 1

Demographic and Psychometric Characteristics of Clients Enrolled in the Audiologic Counseling & Work-Readiness Program

Client	Comm Skill	Grade	Age	Gender	Hearing Loss	Ed Setting & Placement	Race	Basic Ed Level	Performance IQ	Reading Level
1.	Manual	10th	17-11	F	Profound	Total (SDC)	White	3rd	87	3rd
2.	Manual	12th	17-8	F	Mod-Profound	Total (SDC)	Black	4th	–	3rd
3.	Manual	10th	16-6	F	Mod-Severe	Total (SDC)	Hispanic	4th	118	3rd
4.	Manual	9th	14-3	F	Profound	Total (SDC)	Hispanic	3rd	96	3rd
5.	Oral	11th	16-10	M	Sev-Profound	Oral (SDC)	Hispanic	4th	112	4th
6.	Oral	12th	17-6	F	Mild-Profound	Oral (SDC)	Hispanic	4th	72	–
7.	Oral	Grad	22-6	F	Mild-Profound	NA	Hispanic	–	85	–
8.	Manual	Grad	19-2	F	Sev-Profound	NA	Black	–	92	4th
9.	Oral	Grad	18-10	F	Mild-Moderate	NA	White	–	100	–
10.	Oral	9th	15-1	F	Sev-Profound	Total (SDC)	White	7th	–	3rd
11.	Manual	12th	17-7	F	Sev-Profound	Total (SDC)	White	–	72±9	–
12.	Manual	Grad	19-7	F	Sev-Profound	NA	White	6th	111	3rd-4th
13.	Oral	9th	15-1	M	Sev-Profound	Total (SDC)	Hispanic	6th	114	4th
14.	Oral	11th	17-8	F	Mod-Severe	Oral (SDC)	Asian	1st-3rd	58±9	2nd
15.	Manual	11th	17-11	F	Profound	Total (SDC)	Hispanic	–	58±9	–
16.	Manual	Grad	18-11	F	Sev-Profound	NA	Hispanic	5th	95	2nd-3rd
17.	Oral	10th	15-11	M	Mild-Moderate	Continuation	Hispanic	–	–	–
18.	Oral	10th	17-1	M	Mild-Severe	Mainstreamed	White	–	–	–

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Table 1 *Continued*

Client	Comm Skill	Grade	Age	Gender	Hearing Loss	Ed Setting & Placement	Race	Basic Ed Level	Performance IQ	Reading Level
19.	Manual	Grad	20-7	F	Mod-Profound	NA	White	–	102	3rd-4th
20.	Manual	Grad	20-10	M	Sev-Profound	NA	White	–	95	–
21.	Manual	Grad	20-7	F	Profound	NA	Hispanic	1st-3rd	–	–
22.	Manual	Grad	19-7	M	Profound	NA	Hispanic	1st-3rd	–	1st-2nd
23.	Manual	Grad	20-1	M	Sev-Profound	NA	Hispanic	1st-3rd	75	1st
24.	Manual	Grad	20-11	F	Sev-Profound	NA	Black	–	–	–
25.	Manual	Grad	23-4	M	Sev-Profound	NA	Hispanic	2nd-3rd	–	2nd
26.	Oral	12th	18-10	M	Mild-Moderate	Oral (SDC)	Asian	3rd-4th	–	–
27.	Oral	11th	16-4	M	Sev-Profound	Total (SDC)	Hispanic	–	–	–
28.	Manual	10th	16-4	M	Profound	Total (SDC)	White	3rd-10th	–	–
29.	Manual	9th	14-4	M	Profound	Total (SDC)	White	9th	124	–
30.	Manual	11th	17-4	M	Sev-Profound	Total (SDC)	Hispanic	1st-3rd	109	2nd-3rd
31.	Oral	9th	6-11	M	Mod-Severe	Oral (SDC)	Hispanic	3rd-4th	100	3rd-4th

deaf and hard of hearing. The second is the development of an ITP that incorporates the adolescent's IARP, IWRP, and IEP. Although specific treatment plans are developed for the adolescent in the various vocational, educational, and rehabilitation settings, it is essential that a cooperative effort be established to integrate the goals in a transition plan. The third is the successful employment of the majority of the program's participants. The fourth is the positive change in the stereotypical view held by employers towards the deaf and hard-of-hearing. Since many of the young adults who have completed the program have become successfully employed, they are considered valued and capable employees and have become role models for their peers.

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