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Overlooked and Unheard: Abuse of Children Who Are Deaf or Hard of Hearing and Their Experience With CPS and Foster Care

Gabriel I. Lomas¹ and Harold A. Johnson²

Abstract
Children with hearing loss are considered a low-incidence disability population, yet abuse among this population is up to 4 times that of children who are typically developing. The needs among this population are significant, but resources in communities across the nation are few. The authors discuss barriers to disclosure, school-based concerns, and problems with the current child welfare system. A case study offers readers insight into the experience of children with hearing loss in the system. Finally, specific recommendations for marriage and family counselors are offered to improve the foster care experience of children with hearing loss.

Keywords
child maltreatment, child abuse, deaf, hard of hearing

Hearing loss represents the most common birth defect in the United States with an incidence rate of one to three per 1,000 births (Centers for Disease Control, n.d.). In 2005, the National Institute on Deafness and Other Communication Disorders (NIDCD) estimated that there were at least 30,000 children, age’s birth to 5 years with a moderate, severe, or profound hearing loss (National Institute on Deafness and Other Communication Disorders [NIDCD], 2006). NIDCD data also determined that while 67,000 children between the ages of 0 and 19 years were reported as “deaf,” over 260,000 children experienced a “lot of trouble hearing.” The unfortunate reality is that children who are deaf/hard of hearing (d/hh), in fact, all children with disabilities, experience a significantly higher risk of maltreatment than their nondisabled peers (Durity & Oxman, 2006; Sebald, 2008). The incidence of child abuse among children with disabilities has been reported at between 2 and 4 times that of their nondisabled counterparts (American Academy of Pediatrics, 2001; Knutson, Johnson, & Sullivan, 2004; Sullivan & Knutson, 1998) Westat Incorporated (1994) collected data from 35 state child protection agencies and found that 14.1% of children whose maltreatment was substantiated by caseworkers had one or more disabilities. Sullivan (2003) indicated that the number of abused children with disabilities may be even higher as investigators with Child Protective Services (CPS) rarely record the presence or absence of a disability. In the first author’s experience as a counselor and psychological evaluator with d/hh individuals, significant problems in child abuse intervention exist from the initial investigation to placement in foster care. Marriage and family counselors should be familiar with problems related to the maltreatment of children with hearing loss and other disabilities.

Historical Perspective
Marge (2003) and Sullivan (2003) have gone into great detail to outline the history of maltreatment of people with disabilities. Their reports date back to early civilizations, such as the Greeks and Spartans, who placed considerable value on military training. If a young child was perceived as having a disability and potentially unfit for future military service, they were often taken out of the city and abandoned in the surrounding countryside. During the middle ages, the situation changed from abandonment to amusement or oblation. Children with obvious disabilities were given to wealthy nobles to serve as their entertainment. Others were given to monasteries and convents to be raised by clergy. During the industrial revolution, many children with disabilities were given to overcrowded asylums to be raised in deplorable conditions. Many of these children perished due to disease and serious physical abuse. Other children with disabilities were forced to work in factories, as child labor was tolerated in our society at that time. Historical accounts (Sullivan, 2003) report that children were sometimes chained to machines in factories where abuse by

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overseers was commonplace. In the 20th century, abuse against individuals with disabilities was equally visible and rampant. For example, although Jews were the primary targets of the violence in World War II, the Nazi’s also sought to exterminate other individuals thought to be “defective.” Between 1939 and 1944, the Nazi’s murdered approximately 275,000 individuals with disabilities and forcefully sterilized 400,000 exceptional individuals (Sobsey, 1994). Although the abuse of children with disabilities is less visible today, it remains a persistent and significant problem. Goodstein and Callender (2010) reported the abuse of deaf boys by a Catholic priest that went unaddressed for more than 50 years. Although we have made great advances in preventing and responding to abuse, systemic responses, including child abuse investigation and psychological treatments, have been tailored to address the abuse of children who are typically developing and do not fully address the needs of children who have disabilities.

**Educational Trends and Implications**

Federal and state legislation has significantly changed when, where, and how children who are d/hh are both identified and educated (Ross & Karchmer, 2006). Prior to 1975, public school systems were not required to educate children who were d/hh and the majority of such children were educated in residential schools for the deaf, private day schools, or center-based, public school programs that drew children from surrounding school districts. After 1975, due to the passage of Public Law 94-142, the Education of All Handicapped Children Act, all school systems were required to serve all children with disabilities. The law mandated that an “Individualized Education Plan” (IEP) be developed and used to guide and evaluate educational services for children with disabilities. Subsequent iterations of this law, now referred to as the Individuals with Disabilities Education Improvement Act (IDEIA), mandated the instruction of children with disabilities within the “least restrictive environment” (LRE), that is, a nonsegregated educational setting most like that experienced by children without disabilities (U.S. Department of Education, n.d.). During the course of the past decade, the LRE requirement has resulted in a dramatic shift in the education of children who are d/hh. Where previously they were largely educated in segregated settings, for example, residential or day schools for the deaf, or self-contained classrooms within center-based public school programs, most children who are d/hh are now educated in their neighborhood schools, within general education classrooms, with supplemental support provided by teachers of the deaf, speech pathologists, and audiologists (Ross & Karchmer, 2006). Prior to 1990, most d/hh children were not identified until they failed to develop expected patterns of spoken language, that is, between the ages of 2 and 3 years (Culpepper, 2003). By 1998, most states required all newborns to be screened for hearing loss prior to leaving the birthing hospital (White, 2003). Subsequent federal legislation between 2006 and 2010 substantially enhanced both newborn infant hearing screening and the provision of early intervention services via the Early Hearing Detection and Intervention (EHDI) Program. As a result of this Program, the average age a hearing loss was identified and early intervention services begun was reduced from 2.5 years to 6 months (Shulman et al., 2010). These services, as outlined within an Individual Family Service Plan (IFSP), are designed to address infant’s audiological, cognitive, and linguistic needs via the provision of a family centered, home-based approach that utilizes a cross disciplinary team of parents (Guides By Your Side) and professionals (teachers of the deaf, audiologist, and speech pathologist) to help families understand and adjust to their child’s hearing loss and learning needs. Enhancements in EHDI programming were mirrored by technological advancements in digital amplification devices (i.e., hearing aids) and cochlear implants. These advancements, combined with appropriate early intervention support, dramatically increased the number and range of d/hh children who can now benefit from spoken language instruction. As a result, parents of children who are d/hh are increasingly choosing to use speech, instead of speech plus sign, or sign alone with their children.

Improvements in the age of identification of hearing loss and changes in where these children are educated have profound implications for CPS and foster care. EHDI services significantly increase the likelihood that children who are d/hh will be identified at birth and will receive IFSP documented home-based, early intervention services. Technological advances and parental choice significantly increase the likelihood that young children who are d/hh (i.e., ages 1–10 years) will use speech, instead of speech plus sign, or sign alone, to communicate. IDEIA requirement for the education of children with disabilities within the LRE, as documented by an IEP, significantly increases the likelihood that school-age children who are d/hh will be educated in their neighborhood school, within a general education classroom. CPS services can be significantly enhance via the use of IFSP and IEP documentation to establish the child’s disability, medical status, communication needs, and social, cognitive, linguistic, and academic performance. This documentation also provides CPS with critical information concerning the family members and service providers, who regularly interact with a child who is d/hh. Unfortunately, a number of barriers must be addressed before CPS can effectively work with children who are d/hh and their families.

**Barriers to Success**

The ability of CPS and marriage and family counselors to effectively identify and serve maltreated children who are d/hh requires an understanding of why the children experience a greater risk of abuse, why the abuse is unlikely to be reported, and why access to IFSP and IEP documentation maybe limited. The following sections provide this needed information.

The presence of a disability is a recognized risk factor for abuse (U.S. Department of Health and Human Services, 2009). This increased risk of abuse is due to the more limited language skills of many children with disabilities. Limited
language skills reduce their ability to understand and report an abusive situation (Miller, Verson, & Capella, 2005). This limitation also reduces the likelihood that their report of abuse will be either understood or acted upon (Project Ability, 2010). A second factor concerns the relative social isolation experienced by many children with disabilities (Goldman, Wolcott, & Kennedy, 2003). This isolation when combined with an immature understanding of appropriate social behavior, their own sexuality, and essential self-protection skills further increases their risk of abuse (Chandler, 2007). Unfortunately, parents of children with disabilities, and the professionals who work with them, are unaware of the increased risk of abuse, they often do not recognize the signs of abuse, and infrequently provide their children/students with needed information concerning sexuality and self-protection (Hibbard & Desch, 2007; MacDougall, 2000; Obinna, Krueger, Osterbaan, Sadusky, & DeVore, 2005). Additionally, parental concern for the relative social isolation of their children may make them overly receptive to interactional opportunities with other adults, or older children, interactions that again increase a child’s risk of abuse. These older—younger child interactions are often commonplace at residential schools for the deaf, where d/hh children ages 3–21 often live alongside each other in dormitory facilities. According to Sullivan, Vernon, and Scanlan (1987), supervision problems in dormitories at residential schools are a key contributor to the abuse of d/hh children. Finally, children with disabilities are expected to be compliant to adult commands (Hibbard & Desch, 2007). This habit of compliance, without a sufficient understanding of what constitutes abuse, makes children with disabilities easy targets for abuse. These children may not understand the difference between appropriate pain (such as physical therapy, speech therapy, and other common interventions) and pain associated with abuse. Unfortunately, while EHDI and IDEA services address the audiological, linguistic, and academic needs of children who are d/hh, they neither inform, nor prepare, parents, professionals, or children for the increased risk of abuse. Additionally, more than 40% of children who are d/hh have an additional disability (Guardino, 2008). As a result, even when effective early intervention services are provided, children who are d/hh with one or more additional disabilities may fail to develop expected cognitive, linguistic, social, and/or academic skills. This lack of development further increases their risk of abuse. Marriage and family counselors should be mindful of these factors when working with families who have children with hearing loss.

The provision of effective CPS intervention and subsequent counseling interventions depends upon timely and effective reports of suspected cases of child maltreatment. While educators constitute the largest single group of professionals who submit reports of child maltreatment (Kenny, 2004), research indicates a number of barriers to the reporting process (Alvarex, Kenny, Donohue, & Carpin, 2004; Kenny, 2001). Barriers to reporting suspected cases of maltreatment were identified as follows:

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The fact that children who are d/hh are now identified at birth and frequently receive home-based early intervention services until age 3, represents both a critical opportunity and a frustration. Opportunity because existing early intervention programs for families of children who are d/hh already address the five factors that prevent child maltreatment, that is, parent/child bonding, knowledge of parenting skills and child development, parental ability to handle day-to-day stresses, parent networking, and basic family needs (Strengthening Families & Communities, 2011). Frustration because neither home-based nor school-based programs inform parents and professionals of the increased risk of child maltreatment and the barriers that must be overcome to report suspected cases of maltreatment. As a result, only one in three cases of suspected child maltreatment are reported and, in relation to school-aged children, 70% of those reports are to school administrators, and are never passed along to CPS or law enforcement (Alvarez et al., 2004). This lack of reporting, combined with an overworked, under supported CPS system and a recently enhanced, yet still insufficient national data collection system, results in a persistent and significant under count of suspected and confirmed cases of maltreated children with disabilities (Kendall-Tackett, Lyon, Tallaferro, & Little, 2005). This under count, in turn, serves to reduce awareness, understanding, and service for maltreated children with disabilities. As a result, children who are d/hh continue to experience maltreatment at a rate significantly higher than that experienced by their hearing peers (Durity & Oxman, 2006).

CPS efforts require accurate and in-depth information to effectively investigate, and when necessary, use foster care services to protect children who have been maltreated. In relation to children who are d/hh, a great deal of the needed information with regard to counseling and other interventions can be found in either the IFSPs (children aged 0–3 years) or the IEP (children aged 3–21 years). Both the IFSP and the IEP document the child’s disability, needed accommodations, services provided, and the child’s resulting pattern of performance. CPS can gain access to this information by requesting it from the child’s parents. If the parent agrees, the resulting IFSP, or IEP documentation can substantially enhance the investigative and support process. If the parent refuses, the CPS worker must then use pertinent sections of either the 1996 Health Insurance Portability and Accountability Act (HIPPA) to gain access to medical data or the 1974 Family Educational and Privacy Act (FERPA) to gain access to IFSP and IEP data. Alternatively, the family court may provide a court order to allow access to school records. Marriage and family counselors should be mindful that a wealth of information on a d/hh child’s functioning can be found within school documents. Accessing documents early in treatment will allow for interventions that are appropriately tailored to the needs of the child.

HIPPA permits the sharing of information, without parental permission, to CPS agencies to either report a suspected case of child maltreatment and/or to provide CPS requested information in support of an investigation of suspected child maltreatment (Committee on Child Abuse and Neglect, 2010). However, access to IFSP and IEP information is governed by FERPA regulations. Those regulation are designed to protect the privacy of student educational records and do not permit IFSP or IEP information to be shared with any entity outside the educational agency without the express written permission of either the parent, or once the student reaches the age of 18, the student (The Family Educational and Privacy Act [FERPA], n.d.). While FERPA section 99.30, indicates that information can be disclosed without prior permission in “...connection with a health or safety emergency, under the conditions described in section 99.36” (p. 334) Section 99.36 does not define what constitutes a “health or safety emergency.” This lack of clarity is a barrier that may block school systems form sharing IFSP or IEP information with CPS. As a result, the availability of IFSP and IEP information is dependent upon a court order or, for children not taken into care, CPS requesting and parents granting access to this vital information.

**Challenges in Protective Services and Foster Care**

While CPS does a yeoman’s job with limited resources, their system is designed to serve children who are typically developing. Investigators are often untrained in how to respond to a report of abuse against a child with hearing loss. They are rarely aware of when or how to use sign language interpreters. Thus, they may visit a child’s home without an interpreter, making direct communication with the child problematic. Because they are unable to speak with the d/hh child, they frequently interview the caregiver, who may be the perpetrator, and find no reason to believe there is abuse. Thus, abuse may intensify and persist over longer periods of time than with typically developing peers. When marriage and family counselors encounter a d/hh child through the CPS system, it is likely the abuse the child experienced has persisted for much longer than the abuse of children without disabilities.

Once a case is opened and services are provided, CPS employees often have difficulty locating appropriate psychological services for the child. Often, caseworkers will refer the child to a local agency, who may be unable to communicate with the child. If there are no efforts at advocacy on behalf of the child, he or she may go without psychological counseling services.

Numerous other problems with CPS have been identified in the literature. For example, turnover in the agency has been documented as high as 49% (Center for Public Policy Priorities, 2009). This results in multiple caseworkers handling cases and little consistency for children who need specialized services. In my experience (Lomas), a caseworker might send a child to my office for therapy, and then a new caseworker might move the child to another area of town, prematurely terminating our relationship. Although unintended, this situation leaves the child without appropriate psychological services, directly accessible in his or her mode of communication. High turnover among CPS employees results in splintered and inconsistent services for children in their care. Marriage and family counselors may find the need to advocate for appropriate services for d/hh children in the CPS system.

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Compounding the problems inherent in our child welfare system is a lack of appropriate foster care placements for children with hearing loss. If a child with a hearing loss is ordered to be removed from his or her caregiver, they are often placed in settings where communication is minimal or nonexistent, such as a shelter. This may lead to increased fear and anxiety for the child who is unsure what is happening to him or her. Often, the child becomes confused and blames him or herself for the separation from caregivers. The following case study illustrates a common experience for d/hh children in the CPS system.

The Case of Sally

Sally, a pseudonym, is an integration of multiple children with hearing loss the first author served in the CPS system. She was 8 years old when referred to me. The caseworker informed me Sally was in foster care for nearly a year with no psychological services. Sally’s abilities were unknown to the caseworker, as she inherited the case from another caseworker who recently left the agency. She indicated she wanted an informal assessment on Sally, as she was not sure if Sally was intellectually challenged. She reported that Sally was unable to speak and her fluency in sign language was unknown. As I prepared to see Sally, I reviewed CPS records that indicated Sally’s parents had multiple reports of neglectful supervision. The documents indicated that Sally’s parents used drugs, and often would leave her alone for multiple days as they binged on crack cocaine. In the most recent incident, Sally was found naked, roaming the streets of her rural town. She was found by a single, older male individual who alerted authorities. There was no indication she had been sexually abused, but because communication was difficult, CPS was unsure if the man who found her abused her before calling authorities. The court had removed Sally from the custody of her parents for neglectful supervision, who made no effort to see her during the year she was under the supervision of the state. Sally’s foster parents reported no behavior problems at their home. They stated she was cooperative, though they were unable to communicate with her. They stated she attended school, but they knew nothing about the programming offered by the school as they did not attend her IEP meetings.

I took a puppet with me as I walked out to the waiting room to meet Sally for the first time. She sat quietly, and a caseworker assistant who knew nothing of Sally’s situation sat with her. Sally was hesitant to follow me to my play therapy room, but the puppet put a smile on her face and helped her to build trust in me. In our first session, Sally began to talk using a signed English system. The native language of American deaf people is American Sign Language, not signed English. Thus, it was clear to me Sally had been in a public school and had been exposed to formal education, where she was taught signed English. We began to play on the floor with dolls and Sally adjusted her skirt to cover her legs as much as possible. I knew she had been taught manners and modesty in social situations. Sally spent 3 hr with me that day and returned for three more sessions that month. During those sessions, she reported to me that she was taken to a shelter and was very scared to be there. She indicated she was confused and was unsure why she was required to eat and sleep there for several days. She stated she was later moved into a foster care situation, which frustrated her greatly because she could not communicate with her caregivers. However, she cooperated and was hopeful she might be reunited with her parents in the near future. She stated that she had not seen her parents since before they left her at home alone many months ago. After the fourth session, the caseworker informed me that transportation to my office was a burden due to the distance, and I never saw Sally again.

Prevention and Intervention

Sally’s experience was very typical of deaf children who are served by CPS. Often, abuse with children having hearing loss is overlooked and has a longer duration than their typically developing peers. These children have fewer sources for outcry. For example, a typically developing school-aged child is able to outcry to anyone at school from the bus driver to the teacher, the school nurse, or school counselor. However, deaf students in public schools may only see one or two adults, a teacher or interpreter, fluent in sign language in a typical school day. CPS and foster care experiences were so upsetting to deaf people and their supporters in Los Angeles that deaf adults rallied to change the system in their county (Embry & Grossman, 2006). Embry and Grossman explained that CPS had established a number of special units to respond to abuse among recent immigrants from culturally and linguistically diverse backgrounds. The Los Angeles Advocacy Council for Abused Deaf Children held protests and was eventually successful in convincing CPS to establish a special unit to address the needs of deaf people in their county. They were able to mandate that the unit be staffed by caseworkers who were fluent users of sign language. Furthermore, they secured a number of agreements with CPS, one of which required reduced caseloads as compared to their peers in other units. This allowed for more attention to be paid to the children on their caseloads. Furthermore, the unit worked closely with the Advocacy Council to provide community education, including parenting classes, seminars, and panel presentations by deaf survivors of child abuse. Additionally, they worked diligently to recruit individuals in the community who knew sign language to become credentialed as foster parents.

What Therapists Should Know?

The Code of Ethics of the American Counseling Association (ACA, 2005) has a number of points that apply to counselors serving clients with hearing loss. For example, A.2.c. states that counselors should provide “necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients.” Effective communication is essential if one hopes to establish a relationship with clients. The Codes also address a counselor’s Inability to Assist Clients (A.11.b). The
code indicates that counselors should be aware of “culturally and clinically appropriate referral resources.” The ACA ethical codes make it clear that counselors should ensure communication access, even if interpreters are necessary. The codes also tell us that we should be aware of appropriate resources for these clients.

The International Association of Marriage and Family Counselors (2006) ethical code A.4 states, “Marriage and family counselors . . . do not discriminate on the basis of race . . . disability . . . or political affiliation” (p. 4). While counselors have an ethical obligation to provide services or refer to a competent professional without discrimination, we must also keep in mind that we have a legal obligation to serve clients with disabilities. Individuals with hearing loss seeking counseling in hospitals, agencies, and with private practitioners are protected under the Americans with Disabilities Act of 1990. The Department of Justice has fielded a large number of complaints regarding unequal access for people with disabilities. As a result, they created a number of brief handouts to assist service providers with meeting the regulations of the law. The business brief for deaf people accessing mental health services states that providers may be required to use an interpreter for, “Mental health services, including group or individual therapy, or counseling for patients and family members” (Department of Justice, 2003, n.p.).

Marriage and family counselors should seek out resources available to individuals with hearing loss in their communities. While culturally affirmative psychological resources for d/hh people are not available in every community, all urban areas should have resources that counselors can turn to for assistance with such a client. For example, vocational rehabilitation offices have specialists who work with deaf clients. These rehabilitation counselors are often aware of resources that are specific to hearing loss in their communities. Public schools increasingly are educating children with hearing loss and may be a resource for counselors and family therapists who need to locate appropriate psychological and counseling services for clients with hearing loss. Furthermore, many states have an office of deaf services or an equivalent to assist with education and training in the area of hearing loss and communication access. These individuals are typically knowledgeable with regard to resources in local communities.

**Improving Foster Care**

Separating a child from a caregiver is a stressful experience for all children. Children who have hearing loss, especially those who rely on sign language for communication, are often traumatized by the separation from caregivers. These children are frequently placed in a temporary setting such as a shelter or group home, with no clear reason or explanation. While a typically developing child may be comforted with words of assurance by the caseworker, the child with hearing loss is left in the dark. Reading levels of most adults with prelingual hearing loss average fourth grade (Moores, 2001). Thus, most children with hearing loss typically do not understand written messages offered by a caseworker. When communication access is not available, the child is likely to experience the removal from their caregiver as a trauma that is just as significant as the abuse they have endured.

Ideally, all state child welfare agencies should seek to identify appropriate foster care placements for children with hearing loss. Many sign language interpreters, deaf adults, and hearing parents of deaf children are competent users of sign language and may be an excellent resource for this population. Child welfare agencies might use current technology such as electronic mail distribution lists to reach out to individuals who are active in the deaf community. Trainings in foster parenting should be tailored to fit this population. Establishment of group homes that are designed to address the needs of children with hearing loss is another way to improve the current climate for this population. Advocacy for this goal is within the scope of practice for marriage and family counselors, as it may be seen as a social justice action.

**Summary and Conclusion**

Although children with hearing loss represent a low incidence population, their needs are significant and are overlooked by the current child welfare system. This population has faced abuse since the earliest records and continues to face abuse today. Studies (Marge, 2003; Mertens, 1996; Sullivan, 2003; Sullivan & Knutson, 1998) report that their abuse is higher in incidence and is often longer in duration than the abuse of children who are typically developing. Current CPS and foster care systems are designed to meet the needs of children without disabilities. CPS workers are often unaware of school-based resources that are available to them to understand the needs of d/hh children. Successful prevention and intervention programs for d/hh children, such as the Los Angeles response to child abuse and foster care (Sebald, 2008) can be developed in other geographical areas. Through social justice efforts, counselors and family therapists can advocate for the identification and training of foster care placements that are appropriate for children with hearing loss. Education on risk factors, prevention, and intervention with regard to the maltreatment of d/hh children is a crucial first step for marriage and family counselors to meet the needs of this population.

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