



WHAT...ME HARD OF HEARING??

The Silent Epidemic of Hearing Loss

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It has long been estimated that 10% of the American population has a hearing loss, making it a public health issue, third in line after heart disease and arthritis affecting 48 million people (Bouton, 2013). This staggering number spans across the lifespan including children, adolescents, adults and seniors, 27 million of whom are over the age of 50 (Lin, et al., 2011). Baby boomers are reaching the age where their hearing naturally starts to decline, and for some “rock and rollers” hearing loss has already begun. Statistically, it is estimated that by the year 2020, the 55 years and older age group will total 97 million Americans, comprising 28% of the population (Toosi, 2012). Approximately, one third of Americans between the ages of 65 and 74 and nearly half of those over age 75 have hearing loss (NIDCD, 2010). An often cited survey commissioned by the National Council on Aging in

1999 (Kochlin & Rogin, 2000) of 4,000 adults with hearing loss and their significant others reported significantly higher rates of depression, anxiety and other psychosocial disorders than their hearing peers.

Adding to this epidemic are an estimated 700,000 to 800,000 war veterans. It may be surprising to learn that hearing loss is the number one service related disability among our returning veterans, affecting 70% of them (Briggs, 2012, CDC 2010). They not only have to learn to deal with the sudden onset of deafness, but frequently it is accompanied by tinnitus. Tinnitus is a ringing in the ears that, for some veterans, is worse than the hearing loss and can be so disabling that it interferes with their daily lives.

As a hearing impaired psychologist, I have developed my specialty in working with people with varying ranges of hearing loss, each presenting with unique clinical issues.

Across the lifespan, hearing loss presents differently in the clinical interviewing room. A clinician may see young children newly diagnosed; parental grief of not having a “perfect” child; the loneliness and isolation of the “hard of hearing” teen who doesn’t fit in with either his deaf or hearing peers; the young adults who have lost their hearing due to an acoustic neuroma, domestic violence, automobile accident or war.

There has been a great deal of research and attention to understanding the psychological effects of childhood deafness with early diagnosis, educational choices and cochlear implantation. In contrast, there is relatively little on the impact of hearing loss on our veterans or on the baby boomer generation. There are different emotional challenges between those that have early childhood hearing loss and those that have adventitious loss (hearing loss that is acquired after speech and language development). Typically the child deals much more with isolation and loneliness whereas the adult who experiences loss deals with grieving what they once had.

Hearing loss is an **invisible** disability; its true disability is a communication disability. This reduction or a lack of communication often leads to social withdrawal and/or depression. Struggling to understand conversations, music or professional meetings is a daily constant stress. Hearing loss adds an invisible layer of increased stress across the board. Particularly for those who have lost their hearing later in life, depression is very common as one begins to withdraw in their frustration in not being able to communicate with lifelong family and friends.

Unfortunately, for 85% of baby boomers and veterans, hearing loss tends to go largely unnoticed until it becomes severe (Burkey, 2006). For many, wearing a hearing aid means that one is “really old” with

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stereotypical images of yelling at grandpa in his rocking chair, further adding insult to our society's obsessive hold on youth and vanity. For veterans, they are faced with the grief and anger over a condition that they never expected to happen at their young age.

Taking from the baby boomer's iconic MAD magazine's motto 'What...Me Worry?', denial is a common theme with hearing loss. An essential part of dealing with hearing loss is recognizing that stress is inevitable rather than trying to ignore it. The question could be, how long will the individual continue to ignore it before one recognizes that they are being perceived by others to be rude, aloof, or just stupid.

In fact, it is often the spouse or significant other who seeks therapy to deal with their frustration with their spouse's hearing loss and denial of the effects of it. Dr. Sam Trychin, Korean war veteran and former director of training at the Mental Health Research and Training Center for Hard of Hearing and Late-Deafened Adults, openly shares that it took him 20 years to recognize that his own denial of his hearing loss posed far more problems than simply being upfront about it.

The veteran may have a hard time teasing out how much of their angst may be due to their hearing loss or understandable PTSD. In either case, counseling is often seen as shameful and only for the weak (Hutchinson and Banks-Williams, 2006). The divorce rate for veterans is 62% greater than for civilians (Larson, 2012). One could easily speculate that any communication or marital difficulties that existed prior to deployment would be exponentially magnified by their hearing loss.

Typical manifestations of *unidentified* and/or *untreated* hearing loss commonly present as depression, social withdrawal, low self-esteem, unexplained frustration and anxiety. In the geriatric population, care must be exercised in recognizing the symptomatic similarities between Alzheimer's disease and untreated hearing loss (Chartrand, 2005). Most psychologists are not knowledgeable about hearing loss, and as such, not aware of the profound impact that hearing loss may have on a client's self-perception, anxiety and/or depression. An added difficulty is when clients themselves don't understand how their own hearing loss affects them, which not only affects the therapeutic alliance and communication, but often leads to erroneous diagnoses due to lack of experience and knowledge.

The hearing impaired individual's evolving identity shifts on a spectrum from "hearing" to "hard of hearing" or "deaf." Clearly, this needs to be addressed as it necessitates the learning of new coping skills. These skills are critical in learning how to maximize comprehension abilities and at the same time minimize frustration for family, co-workers and friends. The task becomes the learning of more effective stress management and communication skills. As such, psychotherapy can be an important adjunct to a diagnosis of hearing loss.

Psychodynamically speaking, hearing loss can be seen as a form of narcissistic injury. In my clinical work, how a client deals with their hearing loss often provides diagnostic clues. Our youth obsessed so-

ciety contributes to this very narcissistic wounding where they might adopt a "woe is me" attitude or simply withdraw. However, some adults are able to adapt to these losses with more resilience, determination and self-advocacy than others who may view these changes as narcissistic injuries.


With the older adult, there is a strong link between hearing loss and the risk of developing dementia (Lin et al., 2011). It is theorized that the reduction of auditory stimulation leads to social withdrawal, which in turn contributes to emotional and neurological decline. A hard of hearing person who presents with memory loss may actually have never received the information given to them in the first place. The same may be true with making a distinction between disordered thinking vs. a lack of comprehension due to not hearing the information. As such, medical and/or clinical misdiagnoses are often common when hearing loss is not treated.

There are other common diagnostic errors in working with this population, which may necessitate clinical modification. Due to feelings of shame and stigma, there is often a degree of "fakery" whereby the client will agree or appear to understand what is being said. The astute clinician will need to be more proactive and ask the client to repeat or paraphrase what s/he has heard to be sure that s/he understood.

Another common error is to assume that if the speech is "normal," then so must their degree of hearing. Or more fairly said, it is easier to "forget" that there is a hearing loss and to minimize its overall impact on the client's experience of their stress if they speak "normally."

Several nonverbal clues to be alert for include client "forgetfulness,"

blank stares or an intensified and consistent focus on the lips. There may also be numerous misunderstandings or misinterpretations that seem out of character with what has been said. While we all see this in our clinical work, the key distinction is noticing when these become patterns, and as such, it becomes well worth exploring the need for further evaluation of hearing loss.

In conclusion, while it may seem that hearing loss may not appear often in many practices, this will definitely change as our population ages. The more we understand how hearing loss can profoundly affect one's perception, the more sensitive we can be to their sense of reality. The emotional process and journey leading to acceptance of one's hearing loss is often fraught with denial, anger, grief, frustration, depression, loneliness and finally acceptance. With knowledge and our clinical skills, we can make their journey less difficult and, ultimately, provide a better standard of care. 

References

- Bouton, K. (2013). *Why shouting won't help me and 50 million other people*. New York: Sarah Crichton Books/Farrar.
- Briggs, B. (2012). *Hearing loss: The most prevalent injury among returning veterans*. Retrieved from http://www.usnews.nbcnews.com/_news/2012/11/13/14728839-hearing-loss-the-most-prevalent-injury-among-returning-veterans.
- Burkey, J. (2006). *Baby boomers and hearing loss*. New Brunswick, NJ: Rutgers University Press.
- Center for Disease Control (2010). *Severe hearing impairment among military*

- veterans: United States 2010 Morbidity and Mortality Weekly Report*. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6028a4.htm>.
- Chartrand, M.S. (2005) *Undiagnosed pre-existing hearing loss in Alzheimer's disease patients*. Audiology Online. Retrieved from www.audiologyonline.com
- Hutchinson, J., & Banks-Williams, L. (2006). Clinical issues and treatment: Considerations for new veterans. *Primary Psychiatry*, 13, 66-71.
- Kochlin, S., & Rogin, C. (2000). Quantifying the obvious: The impact of hearing instruments on the quality of life. *Hearing Review*, 7, 8-34.
- Larson, V. (2012, November 10). Will marriages be a casualty of post 9/11 conflicts too? Retrieved from http://www.huffingtonpost.com/vicki-larson/will-marriages-be-a-casualty-of-post-9-11-conflicts-too?hpid=hp-top-story-table_1_20121110.
- Lin, F.R., Metter, E. J., O'Brien, R. J., Resnick, S. M., Zonderman, A. B. & Ferrucci, L. (2011). Hearing loss and incident dementia. *Archives of Neurology*, 68, 214-220.
- National Institute on Deafness and Other Communication Disorders (NI-DCD, 2010). *Quick statistics*. Retrieved from <http://www.nidcd.nih.gov/health/statistics/Pages/quick.aspx>
- Toosi, M. (2012). *Labor force projections to 2020: A more slowly growing workforce*. Retrieved from www.bls.gov/opub/mlr/2012/01/art3full.pdf.

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