“Not having understood what was said in a group,’ she reminisces, ‘I would chime in and say the same thing someone else had just said—and everyone would laugh. I would be so embarrassed, I wanted to fall through the floor.’

“Increasingly, her way of coping was to avoid public events more and more and [find] excuses not to mix with people who didn’t understand...

“Will I, like Mother, come to avoid such social occasions...and will my sense of self become less rooted in relationships?...Already, I understand Mother better.”

These words are from the memoirs of David G. Myers, PhD, a social psychologist who reveals his (and his family’s) personal struggles with imperfect hearing. He openly tells of his travail and anxieties caused by hearing loss, and the times he and his mother have been driven into isolation and humiliation by circumstances surrounding hearing loss.

Few would deny that hearing loss can cause anxiety and phobias, but research into such diagnostically significant emotional disorders among persons with hearing loss, other than self-reported questionnaires, is essentially non-existent. Experiencing a hearing loss sets the foundation for potentially untold anxiety-producing situations, even sometimes among people who use hearing aids or assistive listening devices. Living with hearing loss, in many respects, is like living with a chronic illness. It never goes away and it almost always gets worse. Research demonstrates that, as hearing loss progresses up to a moderate level, anxiety increases as well.

Table 1: Anxiety-provoking situations related to hearing healthcare practice.

These situations can provoke varying levels of anxiety in normal individuals. However, the way in which individuals react to these situations determines if it becomes a disorder.

❖ entering an unknown office (vulnerability)
❖ being pressured (coerced) into the office by family members
❖ facing the financial burden of services to be rendered (even if paid by someone else)
❖ meeting new people (staff and others in waiting room) and struggling to hear
❖ filling out questionnaires/case history (having to reveal related/unrelated health issues)
❖ being in a small booth (feeling “claustrophobic”)
❖ taking hearing exam and discussing test results (documentation = confrontation of problem)
❖ feeling concern about cosmetic/visibility issues of hearing aids
❖ feeling incapable of understanding and using amplification successfully
❖ being given a limited trial period (“what if it doesn’t work during this limited time?”); any “trial” period automatically implies “the risk” of failure
❖ realizing after hearing aid use that amplification does not solve all hearing difficulties
❖ dealing with the nuisance or burden of wearing and/or caring for hearing aids

There are innumerable situations in which hard-of-hearing persons can find themselves anxious. Table 1 lists some of these that may occur in a hearing care office. Visiting a hearing provider’s office for the first time, confronting deeply rooted issues regarding hearing loss, or wearing a hearing aid for the first time might make anyone feel anxious. This anxiety often stems from misinformation, fear of the unknown, and co-existing medical conditions.

Anxiety can also be influenced by many other factors, including family history, personality, and general attitude or mental outlook. Experiencing what we would consider “normal everyday anxieties” can be traumatic for persons with a predisposition to anxiety and will result in complex emotional turmoil for some.

Anxiety disorders are serious medical illnesses, which affect about 19 million American adults. They can grow progressively worse if untreated. Between 1990 and 1997, the annualized mean number of office visits documenting a diagnosis of anxiety increased by nearly 50%, and it represents a major public health concern.

Currently, we have no evidence in the literature of the relationship between specific types of anxieties and hearing loss, so any assumptions or conclusions we draw are speculative, based on limited and generalized data. Before examining how anxieties and hearing loss are related, we must first understand anxieties themselves.

 NORMAL ANXIETY

Countless situations can provoke normal anxieties in people. As hearing health care practitioners, we typically think of frequency, duration, and intensity as they pertain to sound. These three factors also apply directly to anxiety: how often it occurs, how long it lasts, and the relative severity of each episode. Normal and abnormal anxiety are differentiated by these three characteristics.

Normal anxiety is transient, and usually associated with a specific stressor. It is often an appropriate reaction. For example, taking a test or being threatened with physical harm can provoke anxiety. And, even routine situations, like running late or meeting a new person, are normal, anxiety-provoking events.

 ABNORMAL ANXIETY

Abnormal anxieties have their own diagnostic classification. The Diagnostic and
SPECIFIC PHOBIA

Specific phobia is a marked, persistent, and excessive fear experienced in the presence of, or when anticipating an encounter with, a specific object or situation that almost always provokes an immediate anxiety response. While there are no data to quantify the incidence of this kind of phobia among those with hearing loss, its symptoms are undeniable.

Many patients develop specific phobia around situations they anticipate will be difficult or impossible to hear in. To avoid feeling left out, embarrassed, isolated, or otherwise distressed, patients commonly avoid specific situations, such as social gatherings.

Twice as many women as men are diagnosed with specific phobia, and in some cases there may be a genetic link. Specific phobia is considered valid as a diagnosis only if the phobic stimulus significantly interferes with the individual’s life. One diagnostic characteristic of this disorder in adults is that the person realizes the phobia is excessive or irrational.

Hard-of-hearing persons who display phobic-like behavior often believe that their behavior is fully justified, logical, and rational. In many situations it may be, in which case this clinical diagnosis cannot be made, despite symptoms that appear to mimic the disorder. For example, someone who avoids a particular bank teller because he or she can never hear and understand this person is not phobic. On the other hand, consider a severely hard-of-hearing individual who avoids hotels for fear of not hearing the smoke alarm. If the person knows that a hotel has special alerting devices, but still refuses to stay there, this could be a diagnosable specific phobia.

ADJUSTMENT DISORDER WITH ANXIETY

Another diagnosable condition is known as adjustment disorder. Based on clinical observation, the type of abnormal anxiety disorder most commonly associated with hearing impairment is adjustment disorder with anxiety.

An adjustment disorder with anxiety is present when anxiety symptoms develop in response to an identifiable stressor that occurs within 3 months of the onset of the stressor (e.g., hearing impairment or worsening hearing impairment). These symptoms, which include nervousness, anxiety, worry, or jitteriness, cause marked distress beyond what would be expected from the hearing loss alone. There is also significant impairment in social or occupational functioning from the anxiety symptoms.

People with this disorder have an increased risk of suicide attempts or actually committing suicide. These individuals are also likely to be less compliant with treatment recommendations, making treatment more difficult.

Based on empirical clinical evidence, Statistical Manual for Mental Disorders sections on anxiety and adjustment disorders describe the various types. Table 2 presents pre-existing anxiety disorders that can be exacerbated by hearing loss. For example, a client with a pre-existing panic disorder purchases hearing aids for the first time, goes into a particular situation, and cannot hear with them. This may be enough to trigger a panic reaction.

### Table 2: Types of anxiety disorders that can be exacerbated by hearing loss (partly derived from the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition). Note: To qualify as disorders, these conditions must result in at least 6 months of persistent and excessive anxiety and worry.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder</td>
<td>Recurrent, unexplained panic attacks; can be situation-induced. Example: multiple occasions of panic attacks, some of which may be related to not hearing well.</td>
</tr>
<tr>
<td>Social phobia</td>
<td>Persistent fear of social or performance situations in which embarrassment may occur. Example: avoidance of social gatherings for fear that hearing loss will cause embarrassment.</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder and/or personality disorder</td>
<td>Recurrent behaviors severe enough to be time-consuming or cause marked distress or significant impairment. Example: compulsion to keep changing fully charged hearing aid batteries for fear of their going dead.</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>Development of characteristic symptoms following exposure to an extreme traumatic stressor. Certain sounds often precipitate a startle reflex in sufferers, in turn triggering past trauma associations. Example: Vietnam vet fitted with hearing aids hears the roar of a helicopter, which now sounds abnormally loud, triggering an emotional response.</td>
</tr>
<tr>
<td>Acute stress disorder</td>
<td>Development of characteristic anxiety, disassociative, and other symptoms that occur within 1 month after exposure to an extreme traumatic stressor. Example: can be same as for PTSD.</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>Excessive anxiety and worry (occurring more days than not over at least 6 months) about a number of events or activities, and not due to a general medical condition.</td>
</tr>
<tr>
<td>Anxiety disorder due to a general medical condition</td>
<td>Clinically significant anxiety judged to be due to the direct physiological effects of a general medical condition. Example: a person suffering from anxiety caused by a medication becomes more easily anxious due to poor hearing.</td>
</tr>
<tr>
<td>Substance-induced anxiety disorder</td>
<td>Prominent anxiety symptoms judged to be the direct physiological effects of a substance. Example: addiction to, and/or use of, alcohol or drugs can induce anxiety, which can render a person more susceptible to anxiety from other stressors, including poor hearing.</td>
</tr>
<tr>
<td>General anxiety</td>
<td>Disorders with prominent anxiety or phobic avoidance that do not meet criteria for any specific anxiety listed above.</td>
</tr>
</tbody>
</table>

WEB SITES ADDRESSING ANXIETY

(Many sites offer search capabilities)

- www.aabt.org [Association for Advancement of Behavioral Therapy]*
- www.adaa.org [Anxiety Disorders Association of America]
- www.freedomfromfear.com [Freedom from Fear]
- www.nami.org [National Alliance for the Mentally Ill]
- www.nimh.nih.gov [National Institute of Mental Health]
- www.nmha.org [National Mental Health Association]
- www.psych.org [American Psychiatric Association]*
- www.anxietynetwork.com [The Anxiety Network International]

http://anxiety.ohio-state.edu [Ohio State University]

* Patient viewing not encouraged
it appears that adjustment disorder with anxiety is the most common anxiety disorder in hearing-impaired individuals because the symptoms are very likely derived from a common psychological vulnerability. Theoretically, we are all "wired" through genetics and life experience to navigate through the daily vicissitudes of life, while incurring the least stress possible. A big component of this wiring is the type, quality, and flexibility of various coping abilities.

When a person's coping abilities are stressed beyond their normal capabilities, symptoms arise. For example, some people become depressed, some anxious, some act out, others use drugs or alcohol, depending upon their individual wiring. The basic underlying nature of an adjustment disorder is just such a breakdown or inadequate functioning of one's coping abilities.

Hearing impairment can present a formidable challenge for otherwise adequately coping adults. In our society, subtle and not-so-subtle value judgments are placed on aging and disabilities. On a more personal level, many people, especially men, have deeply rooted identification with their physical well-being. For women, the fracturing of their normal mode of social relatedness, that is, talking and listening, can be upsetting.

Some clients adapt easily and well to the awareness of their hearing loss and to the use of hearing aids. Their coping mechanisms already possess the "wiring" necessary for adapting to the hearing loss. Others can only gradually shift their ability to cope with this higher level of demand. These people are more anxious when initially faced with their hearing problem and/or using hearing aids, but their anxiety gradually dissipates over weeks or months. These patients' coping mechanisms are able to bear the new challenge.

Other hearing-impaired clients initially give the appearance of adequately adapting to their hearing aids. They seem to be cooperative and compliant with their usage. However, a few months later, they suddenly stop using the hearing aids. Often, the initial appearance of good adaptability was only for show. Such people may have been trying to please their spouse, other relatives, or friends, and ignored their own anxieties about their hearing loss and the use of hearing aids. Because their anxiety was never confronted or because their anxiety is too overwhelming, their coping mechanisms are unable to rise to the occasion of dealing with the hearing loss or hearing aids.

A final group consists of people who are never able to cope adequately with their hearing impairment and have ongoing anxiety symptoms. Some of them may go on to develop much worse anxiety symptoms or other psychiatric symptoms, which are then classified as other disorders.

Many people find that hearing aids are an intrusion in their life. This often becomes evident during the trial period. Such patients often display significant levels of frustration in adjusting to hearing aids. Once this kind of negativity begins to dominate the hearing aid experience, underlying psychological components are likely to begin playing a greater role, increasing the person's difficulty coping with hearing devices and what they represent.
Giving up on hearing aids, or never using them in the first place, commonly results in feelings of isolation. Many of these cases will fall under adjustment disorder because the situation will exceed most people’s normal coping abilities. The hearing care professional’s ability to display calmness and convey confidence that the situation will be mastered is a critical factor in a successful outcome.

ANXIETY DISORDERS AND DEPRESSION

It is very common for anxiety to coexist with depression, especially in later life. In a study of 200 consecutive patients seen for primary care treatment, 46% of patients with anxiety disorder also presented symptoms of depression. For this group, the rate of care is poor, and clearly deserves our attention. Both anxiety and depression are also common in alcohol abuse. Both conditions may be under-diagnosed in older Americans because the criteria on which diagnosis is based, The Diagnostic and Statistical Manual of Mental Disorders, “are developed from studies of younger adults...without regard for atypical symptom presentations, high occurrence of depressive and medical comorbidity, and influence of aging-related psychosocial changes on the clinical picture.”

CONSIDERATIONS IN REHABILITATION

The person who waits years to seek hearing help is more likely to possess features of an anxiety disorder than to demonstrate self-confidence, cheer, an easy-going way, and freedom from emotional encumbrance. While it is a challenge to uplift such downtrodden patients, we do not usually consider that the fear of not hearing can itself become a process of progressive anxiety.

Struggling to hear for many years often establishes predictable patterns of behavior and attitude, such as avoidance, isolationism, low self-esteem, anxiety, and depression, which will affect hearing aid outcome. The more significant the hearing loss, the greater the anxious reactions.

TREATMENT OPTIONS

Treatment for anxiety disorders generally includes a regimen of psychotherapy and/or pharmacotherapy, and is often very effective. Details and discussion of these treatments are beyond the scope of this paper.

In general, if a hearing healthcare professional is unable to calm a patient adequately or finds that the anxiety is interfering with the patient’s adjustment to amplification or with his or her family or work, it may be appropriate to make a referral to a mental health professional.

However, referral itself can pose a set of challenging problems for the hearing care professional. These may include patient resistance and suspicion that we are not trained to know when such referral is needed. Even if we do refer successfully, many patients who are placed on psychopharmacologic treatment are ultimately non-compliant with their medication. Successful referrals will require that mental health professionals have experience in the area of hearing health.

We must always bear in mind that these same symptoms are also features of various anxiety disorders. This fact increases the need for our rehabilitation
efforts to seek deeper insights. Complicating the mix are factors stated earlier: family history, personality, general attitude or mental outlook. For example, shyness has been correlated with low sociability and loneliness, adding stressors to an already challenging situation for rehabilitation. That is, providing amplification for a shy patient suffering from anxiety will do little good if the person fails to interact with others.

Another consideration is that the anxieties our patients experience can be intertwined with their relationships with us (Table 1). Hearing health care is challenging. It is a problem-solving grind that can wear down any practitioner unequipped to handle the frustrations, setbacks, turmoil, and unpredictabilities of clinical practice. When we see clients, they usually come with problems for us to solve.

Expert counselors Kennedy and Charles sum up the challenges: “It is stressful to work with anxious individuals because it is difficult for them to explain what their problem is. The very nature of it, wrapped in vagueness, complicates the effort to understand them right from the start…”

They continue, “These persons need a great deal of acceptance and understanding. This is complicated for them by the fact that they have grown very cautious [about] committing themselves to other persons precisely because of the nature of their anxious difficulties.”

No less significant is, in the eyes of some consumers, the somewhat tainted reputation of the hearing aid industry, which may raise issues of trust and potentially increased anxieties.

Frustrated and anxious practitioners give non-verbal cues that can exacerbate hidden or overt anxieties in our patients. Whereas volatile patients may resolve their anxiety through good coaching and counseling, anxious practitioners may actually bring out their patients’ worst fears and anxieties. Hence, in our effort to reduce anxiety in a patient, we must begin by recognizing our own limits and failitudes, taking care not to react negatively to distressed patients, and remaining calm as we provide strategic support and comfort.

When we consider all the challenges of hearing aid fittings—occlusion, discomfort, distortion, over-stimulation, remakes, and time delays, to name a few—we can see how, despite our best efforts, what we hoped would be a solution becomes, instead, an unnerving, unsettling, and upsetting experience for many of those we seek to serve. The hearing aid return rate speaks directly to this.

When patients return hearing aids and never return to our offices, they leave with complex hearing problems and little or no hope of resolving them. Many failed candidates will be facing untold anxieties that may lead to depression, employment difficulties, and relationship problems. These are terribly sobering considerations. And, because they are so sobering, we must make every effort to consider seriously the impact of potential anxiety-provoking and phobic responses in our patients. This consideration will make us more effective rehabilitation therapists. And it provides us with one more window into the complexities and deeply veiled issues often hidden from our view.

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REFERENCES