Clinical Indications for Psychological Treatment of Hearing-Impaired Adults

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This paper provides the rehabilitative audiologist with information important to making referrals to mental health professionals. Such referrals require information relevant to recognizing a difficulty that requires mental health treatment and making the referral in such a way that insures client cooperation. In addition, this paper discusses the establishment of clinics so that the appropriate follow-up can be conducted by both audiological and mental health professionals.

It is common practice in audiology clinics to screen their adult clients for possible acoustic tumors, conductive losses, and other disorders demanding medical intervention. Similarly, the rehabilitative audiologist should be aware that many of the behaviors presented by some hearing-impaired persons resemble characteristics of certain emotional problems. Ramsdell (1978) described the ramifications associated with hearing loss at the speech, warning signal, and primitive levels. These include withdrawal, conversation manipulation, phobic behavior, paranoia, and increased anxiety in interpersonal relationships.

Some clients exhibit obvious mental health problems. A 76-year-old female client came to the clinic complaining of tinnitus. She had read a local newspaper article discussing tinnitus masking and was referred to the Aural Rehabilitation Clinic by a friend. She did not present the usual noise, pure-tone, or other tinnitus symptomotology. She did, however, report hearing her husband's voice calling, "I love you . . . Come and join me . . . I will be with you forever . . ." Subsequent discussion revealed that her husband died ten years previously. The client in this example did not demonstrate typical symptoms associated with an auditory disorder and required the assistance of a mental health professional. In most cases, however, the decision whether to refer or to treat is more difficult. The purpose of this paper is to present the

psychological symptoms that may indicate mental health referral, to discuss an appropriate method to make such a referral, and to outline a possible cooperative referral process between aural rehabilitation clinics and the mental health professionals.

SYMPTOMS OF EMOTIONAL DYSFUNCTION

A number of psychiatric conditions have hearing-related components in their presentation. These conditions are generally psychotic in nature due to the distortion of reality that occurs and the high degree of impairment in everyday actions. The following descriptions do not comprehensively represent the conditions as outlined in diagnostic manuals and are limited to those aspects relevant to this discussion. Complete descriptions are available in Zax and Cowen (1972) and American Psychiatric Association (1968).

Schizophrenia

Among the classical symptoms of schizophrenia are auditory hallucinations. Patients typically report a sensation of hearing voices. The voice may be a familiar-sounding one, as in the case of the female client earlier presented, or an unfamiliar one, as in the case of an individual who hears from a spiritual being. Hallucinations can also involve repetitive and distracting noises, such as bells, ringing chimes, insect noises, environmental noises, and music. Hallucinations are characterized by the lack of an external stimulus which can explain these phenomena. This is particularly noteworthy when providing rehabilitative treatment to tinnitus clients.

Paranoia

Other emotional conditions have more subtle hearing-related components. Some paranoid states exist in which people have an exaggerated sense of hearing or increased hearing sensitivity while audiologic data are essentially normal. This complaint is typically accompanied by a high degree of suspicion and discomfort around people. A person may believe that others are actually talking about her/him and may overinterpret or personalize situations that most people regard as irrelevant. As in the case of hallucinations, external verification of these phenomena is not possible, yet their existence is highly significant to the person experiencing them. The next two emotional disorders represent a less serious impairment and do not affect the sensory mechanisms.

Mood Disorders

Depression and anxiety compose the major types of mood disorders. Depression typically manifests itself with a multitude of complaints: insomnia, loss of appetite, lowered sexual drive, guilt, fatique, and uncontrolled emotional

outbursts. Anxiety is experienced as a sense of worry about the future, generalized pressure in everyday living. Nearly all people experience a degree of anxiety or depression at some point in their lives. Mental health referrals are indicated when these moods dominate a person's life and change daily living habits.

Adjustment Reactions

A considerable amount of research has been conducted on how changes in life styles affect the amount of stress a person experiences (Rahe, 1974; Rahe, 1978; Rahe & Arthur, 1978). Situations such as divorce, marriage, death of a loved one, and financial problems have been demonstrated to affect physiological functioning. Research findings have shown that people with high levels of stress experience many more medical problems compared with people experiencing low amounts of stress. A number of clients examined in medical offices will not acknowledge their distressing feelings, preferring instead to make what sounds like an organically based complaint. Martin (1978) and Rintelmann (1979) have both postulated that there may be nonorganic factors that influence hearing assessment. Indeed, these same nonorganic factors can influence rehabilitative treatment.

A 71-year-old woman was originally seen for aural rehabilitative treatment in July 1979. Although she has progressed favorably, in some aspects of rehabilitative treatment, she still has difficulty with her hearing aid. She was seen on many occasions in the clinic for "hearing aid adjustment" or "earmold modification." During these visits, however, there was more discussion about her husband of 50 years who had died the year before than orientation or adjustment to the instrument. Due to focus of the conversations during these follow-up visits, the clinician concluded that the woman was requesting these appointments more from a need to ventilate her grief than to receive aural rehabilitation services.

MAKING AN APPROPRIATE MENTAL HEALTH REFERRAL

Audiologists may have difficulty informing a client of their decision to make this referral because they do not know what to expect. Due to fear that a client may become insulted or angry, they may hesitate to make a referral to a mental health professional.

A 31-year-old male with a severe unilateral hearing impairment was seen for rehabilitative treatment during the Fall of 1979. The client did extremely well on all rehabilitative tasks. There were no other aural rehabilitative techniques utilized with this individual. He did, indeed, feel rather self-conscious about the hearing impairment and an associated slight facial nerve paralysis. Although a mental health referral was indicated, the referral was not initiated as the patient was extremely sensitive to such a suggestion. Rather, he was

terminated from aural rehabilitative treatment.

An appropriate method for making this referral consists of moving the client from the examination room into an office setting to insure privacy and respect. Clinicians should outline the tests conducted, including the results, and describe their findings in a matter-of-fact manner. The following imaginary dialogue suggests one approach.

Clinician: The results of these treatment sessions show that you have gained maximum adjustment to your hearing loss. However, you still appear to have difficulty adjusting to your circumstances. I would like to refer you to a clinic that specializes in emotional problems. I realize your current situation causes you much frustration.

Client: What? Do you think I'm crazy or something?

Clinician: No, not at all. Your complaints are very real to you. I intend to stay in touch with the person to whom I refer you. May I have your permission to contact the clinic?

Client: I guess that would be O.K.

Clinician: Do you have any questions before I call?

There are appropriate ways to make mental health referrals that do not alarm or make the client uncomfortable. The typical fear about mental health counseling revolves around being identified as "crazy" (Wegman, 1978). A number of people who would like to ventilate to a mental health professional simply do not make that request because they believe that only "crazy" people need mental health services. The audiologist needs to be aware that some people have this stereotype of mental health.

INTER-AGENCY RELATIONSHIPS

Clients who are referred from the audiology clinic to the mental health clinic may decide not to go if the audiologist suggests that they make their own appointment. Mental health agencies typically are busy places that have a high demand for their services and may not follow up on missed initial interviews.

One way of insuring that referrals are effected consists of having a liaison appointed from each clinic. Both liaisons would meet on a regular basis to evaluate the referral process and facilitate inter-agency communication. In this way the client becomes more comfortable with the referral by observing the clinician handling the process efficiently and effectively.

Another advantage of coordinating referrals through liaisons is that a high level of continuity of care is maintained. The clinicians can also communicate regarding their respective treatment efforts with the client. Clients feel more significant knowing that both professionals are concerned about their condition.

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