

ASPECTS OF TRAUMATIC AND MILITARY PSYCHOGENIC DEAFNESS AND SIMULATION

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The examination of hearing disability compensation cases presents complicated problems in clinical management. Because of the difficulty existent in securing full cooperation of these claimants and of refining the audiological test battery in order to circumvent exaggerated hearing losses, certain clinical methods and ideas are evolving in the United States.

The largest disability benefits system in the United States is administered by the Veterans Administration. One section of this program is devoted to the evaluation and treatment of hearing impairment and this program is conducted in V.A. Audiology clinics and in contract clinics. In the Los Angeles Audiology and Speech Pathology Service, the case of audiological compensation examinations consisted of approximately fifteen hundred per annum. The problem cases encountered and the difficulties in management have suggested a governing general rule in this type of examination: all hearing losses encountered in medico-legal compensation work should be proved. Many claims for disability ratings were originated on the basis of spoken and whispered voice tests, a pure-tone audiogram, or a simple statement from a general practitioner without audiological evidence. Often the statement simply said: total bilateral hearing loss. In this connection it is interesting to note that with this type of case where normal or near normal hearing had existed previously, we saw at most only two or three cases with total hearing loss.

I believe that most authorities agree with Dr. Glorig, who considers spoken and whispered voice tests useless for determining line of duty progression, aggravation, eligibility for retirement, or amount of disability. In the past, these tests have served to establish what appears to be irreversible hearing loss, even though later evidence proves them erroneous. Thus, in addition to being useless, they must be disproved in re-evaluating disability ratings.

One very valuable feature of Veterans Administration Audiology is that all medical treatment records are available, from the time of induction through release from military service, as well as V. A. treatment records following military service. A review of all available information relating to evaluation of hearing is mandatory before audiological examination of the claimant. Particularly pertinent is internal evidence of improvement, sudden increase in hearing loss not accounted for etiologically, variation in compensation ratings, and use or lack of use of hearing aids. When full cooperation is lacking, valuable information related to the hearing problem

may be gleaned from a study of psychological and social service reports. As an example, it has come to my attention recently in discussing these problems with a colleague from another section of the country, that ninety percent of patients referred from a depressed area where unemployment was prevalent presented non-organic hearing problems. Invariably, their income had been reduced in the recent past before appearance for audiological examination.

Highly significant in the Los Angeles office was the incidence of unilateral deafness. Approximately one-third of all cases presented hearing losses of this nature and of these a significant number demonstrated exaggerated hearing loss, usually limited to the allegedly poorer ear. In the clinical management of this type of case, rigorous standards of testing were developed which included pure tone air and bone conduction tests for both ears, masked and unmasked pure tone thresholds by air conduction for the poorer ear, Stenger testing, masked and unmasked speech reception threshold tests and discrimination tests. In addition, EDA tests were performed on the poorer ear, as well as delayed sidetone tests.

Another type of case frequently encountered in compensation work is the one claiming total bilateral hearing loss. The true organic case of total bilateral deafness where the person formerly had normal hearing invariably demonstrates an eagerness to communicate, to pick up visual cues and to speech read, even if the attempt is only partially successful. By contrast, the non-organic problem case claiming total deafness invariably takes great pains to thwart communication by not looking at the examiner, reading the newspaper with exaggerated concentration, not responding to his name being called, or to movement in his immediate vicinity. With these cases, a study of the speech production is most important; even with relatively short-term total hearing losses it can be noted that speech deterioration sets in quickly. Speech melody becomes restricted, final consonants tend to disappear and speech power intensity changes occur. Also, general communication should be evaluated. Such questions as the following should be considered: does the patient speech read or use the telephone, are hearing aids used, etc. In this connection, a particular case comes to mind wherein a claimed total hearing loss occurred within a very short time, without adequate medical explanation. Because cooperation was lacking, extensive testing was conducted, including sodium pentothal sessions, but results were indefinite. A rating for total loss of hearing was deferred, whereupon the patient went to another clinic for examination. A rating was made on the basis of the second clinic's test results, which consisted primarily of psychological evaluation because no clear cut responses to auditory stimuli could be obtained. The case was rated as bilateral total deafness with no residual hearing. Subsequently, however, the patient returned to the jurisdiction of the first clinic and, although claiming total deafness, communicated very adequately with clinic personnel over the telephone, when requesting appointments, hearing aid information, etc. Obviously, there was residual hearing, with a strong possibility of normal or near-normal hearing. Experience with this type of case has shown that the permanent rating of total bilateral hearing loss should be deferred while specialized re-examination is conducted over a period longer than necessary in cases presenting some hearing.

Great ingenuity and adaptability are required with cases claiming hearing losses which are feigned. Tensions develop early within such test sessions. The more experienced the clinician, the less emotion is permissible in clinician-patient communication. The experienced clinician must constantly evaluate his own techniques, the calibration of his equipment and the dynamics involved in the patient's exaggeration. Different approaches are desirable, according to the talents of the individual clinician; some prefer to begin testing using speech audiometry, others EDA, still others pure tones. A critical element is whether or not to allow the patient to know that he is suspected of exaggerating, and if so, when. In our experience, we have found that, rather than accuse the patient, it is much more desirable to remain objective and explain as early in the test battery as possible after it becomes obvious that he is not cooperating, that inconsistencies exist between tests which must be resolved and to ask the patient whether or not he can account for the inconsistencies. It becomes evident early to most of those who exaggerate and are therefore under tension that suspicion exists in the mind of the clinician. It is unnecessary and unwise to use the terms malingering or exaggeration. It is wise to acquaint the claimant with the fact that all tests and inconsistencies will become a part of the permanent record of the case, and will be available for future reference to other clinics. Another point developed at this time is that, should hearing deteriorate, it would then be desirable to have clear records available, in order that later hearing loss would not be confused with possible exaggeration. When a complete test sequence has been finished, it is often more valuable to have a patient return for a later appointment than to repeat another full re-test sequence. It has been claimed that in some clinics patients are tested for as long as six to eight hours during one appointment. It became our conviction that in outpatient audiological testing, maximum time should not exceed two and a half to three hours, because clinician and patient efficiency drops severely beyond this time. When it was necessary to have the patient return, it was found valuable to have the second test conducted by a different audiologist. In difficult cases, when a third appointment was necessary, a third audiologist tested. In this manner, each succeeding audiologist had the advantage of reviewing the background material in the case, of coming to the problem with a fresh view and finally of having the patient re-explain his problem, which usually centered around complaints about the previous audiologist, incomplete directions for giving responses, fatigue, heat, etc. etc.

In fourteen years' experience in medico-legal compensation work, I have observed that true psychogenic hearing loss is extremely rare. In fact, the use of the term psychogenic is rapidly fading and is being replaced with the term „non-organic“, which, of itself, carries no evaluation of the patient's psychological and volitional processes. A large number of patients encountered in this work had rated neuropsychiatric disabilities. In general, we found it no more difficult to establish organic hearing levels with these cases than with nonpsychiatric hearing disability cases.

In dealing with sophisticated patients, it is interesting to hear them discuss symptoms related to their claimed conditions. Many apparently read a moderate amount of information on symptoms but few read extensively enough

to know the intricate details necessary for complete diagnosis. There are many cases claiming Menière's disease, usually on the basis of one or two episodes of dizziness, but few legitimate claims are established.

It is very difficult in the time allotted to cover such a broad subject as traumatic and psychogenic deafness. I have attempted to describe, in a general way, experience based on fourteen years service with the Veterans Administrations Audiology and Speech Pathology Program. This is a vital, interesting and unique program and, because of the nature of the problems involved, because of the scope of the patient population, and because it serves as a fertile training ground for clinicians, it stands as a model for similar programs.

Résumé français pas reçu.

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