

Psychological Profile and Social Behaviours of Hyperacusis Patients

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Introduction

According to epidemiological studies, increased noise sensitivity refers to an abnormal subjective response to external sounds, with a prevalence of between 8% and 15.2% in the adult population. Because the basic neural mechanism of hyperacusis is still unknown, therapies for this often-devastating symptom remain elusive. In a prospective case-control design, the goal of this study was to assess psychological profiles in patients with presbycusis without tinnitus. Following an audiological evaluation, all subjects were given the following questionnaires: the hyperacusis questionnaire, the brief symptom inventory, and the modified somatic perception questionnaire. Patients with hyperacusis had significantly higher total and subscale HQ scores than controls [1].

Description

They also had higher MSPQ scores and significantly higher mean values on the BSI's somatization, obsessive-compulsive, interpersonal sensitivity, depression, and anxiety subscales. These findings indicate that psychological distress, as manifested by increased somatic attention, somatization, anxiety, and depression, is an important factor to consider for a thorough diagnosis and effective treatment of hyperacusis. Patients seeking help for hyperacusis should have their psychological distress assessed in order to receive an accurate diagnosis, regardless of their hearing abilities. More research is needed to determine the pathological mechanisms underlying the onset of hyperacusis in patients with normal hearing and those with sensorineural hearing loss [2].

The abnormal subjective response to external sounds is referred to as increased noise sensitivity. Even though noise exposure and subsequent noise-induced hearing loss are considered major risks in many cases, it is considered an individual trait that does not necessarily depend on hearing loss. It could be considered an abnormal loudness perception in comparison to environmental sounds that are normally tolerated or even ignored by most people. Hyperacusis differs from phonophobia, which typically refers to sensitivity to loud sounds, such as that associated with migraine and misophonia, which indicates an abnormal emotional reaction to specific sounds. It should also be distinguished from loudness recruitment, which indicates a faster increase in loudness perception in comparison to a slower increase in loudness perception.

The prevalence of hyperacusis in adults is unknown, but two epidemiological studies suggest it ranges between 8% and 15.2% in the adult population. It is significantly higher in women and people with hearing disorders than in those with normal hearing. Several occupations have been identified as high risk factors for hyperacusis. According to its main clinical feature, four subtypes of hyperacusis have been proposed: excessive loudness, annoyance, fear, and pain, in which sounds are perceived as uncomfortably loud, unpleasant, frightening, or painful, respectively. While it may be difficult to distinguish between these categories in clinical practise, this classification may be useful in neurophysiological research. Because the basic neural mechanism of hyperacusis is still unknown, therapies

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Received: 02 March, 2023, Manuscript No. abp-23-99927; **Editor Assigned:** 04 March, 2023, PreQC No. P-99927; **Reviewed:** 16 March, 2023, QC No. Q-99927; **Revised:** 21 March, 2023, Manuscript No. R-99927; **Published:** 28 March, 2023, DOI: 10.37421/2472-0496.2023.9.195

for this often-devastating symptom remain elusive [3].

According to the so-called "Central Gain Model," these findings point to excessive gain enhancement in response to peripheral auditory stimuli. According to this model, despite the absence of clinically obvious hearing loss, hyperacusis is associated with increased sound-evoked activity in multiple auditory processing centres, including the auditory cortex, medial geniculate body, and inferior colliculus. Hyperacusis, on the other hand, has been reported in patients with post-traumatic stress disorder, anxiety disorders, anxiety-related personality traits, and depression. Avoidance behaviour towards self-exposure to everyday sounds has also been documented, which contributes to the psychological well-being of hyperacusis patients [4,5].

Conclusion

Finally, psychological distress is more pronounced in hyperacusis patients than in controls, as evidenced by the higher global severity index score in the former. This association's causality is not well established. After an acute stress task, women with high levels of emotional exhaustion developed hyperacusis, according to one study. This finding could imply that abnormal auditory sensations are the result of a psychosomatic effect. If women with high levels of emotional exhaustion are not acutely stressed during the testing, an increased LDL test will not detect signs of hyperacusis, so these results cannot be extended to chronic conditions. On the other hand, sound sensitivity may be a stressful condition due to avoidance behaviours and social isolation, resulting in stress, anxiety, and depression.

Overall, it has been demonstrated that psychological distress, as manifested by increased levels of somatic attention, somatization, anxiety, and depression, is an important factor to consider for a complete diagnosis and effective treatment of hyperacusis. Thus, regardless of normal hearing function, patients seeking help for hyperacusis should be evaluated for psychological distress in order to receive an accurate diagnosis. More research is needed to determine which pathological mechanisms are involved in the onset of hyperacusis in both normal subjects and patients with sensorineural hearing loss.

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How to cite this article: Gherpelli, Riccardo. "Psychological Profile and Social Behaviours of Hyperacusis Patients." *Abnorm Behav Psychol* 9 (2023): 195.