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Psychosocial Adjustment and Depression in Adult-Onset Hearing Loss: A Case Study Approach

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Abstract: Adult-onset hearing loss is a significant yet often overlooked psychosocial stressor, particularly in low-resource settings where access to rehabilitative and mental health services is limited. This case study presents the psychological formulation and intervention of a 36-year-old male construction worker who developed moderate-to-severe bilateral sensorineural hearing loss, followed by persistent depressive symptoms, irritability, and social withdrawal. An eclectic, phase-based intervention was implemented, integrating Cognitive Behavioural Therapy (CBT), Supportive Psychotherapy, and Psychoeducation, with modifications to accommodate hearing impairment. Therapy focused on emotional validation, restructuring maladaptive cognitions, behavioural activation, and family involvement. Clinical progress was evident in improved mood, interpersonal communication, and occupational engagement. The case underscores the complex interplay between sensory disability and emotional well-being and highlights the efficacy of adaptable, low-cost psychological interventions within public healthcare systems. Findings reinforce the importance of culturally and contextually sensitive mental health support for individuals navigating the psychosocial impact of sudden sensory loss.

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1. Introduction

Acquired hearing loss in adulthood is a prevalent sensory impairment with significant psychological and social consequences. Beyond its impact on auditory functioning, hearing loss often disrupts communication, social roles, and identity, contributing to emotional distress and maladjustment (Kyle et al., 2024). Adjustment is a complex, individualized process shaped by personal, interpersonal, and contextual factors, with many adults experiencing frustration, withdrawal, or denial before reaching acceptance.

Emerging evidence highlights a strong association between adult hearing loss and mental health conditions, particularly depression and social isolation (Tsimpida et al., 2022; Jiang et al., 2022). Hearing loss may reduce quality of life and exacerbate psychological distress, especially when compounded by low socioeconomic status or limited support systems (Tsimpida et al., 2022). Social-emotional difficulties are further amplified when hearing loss remains unacknowledged or untreated in clinical care (Timmer et al., 2024).

Given these associations, it is imperative for mental health professionals in general hospital settings to recognize and address the psychosocial dimensions of hearing loss. This case study presents an integrative psychotherapeutic approach for managing adjustment difficulties in an adult with acquired hearing loss, situated within a district hospital context.

Case Formulation

The client, a 36-year-old married male, employed as a daily-wage construction labourer, presented to the outpatient department of a district hospital with complaints of persistent irritability, social withdrawal, and reduced interest in previously enjoyed activities over the past six months. The symptoms began following a sudden onset of bilateral sensorineural hearing loss secondary to an untreated ear infection.

Psychiatric evaluation revealed no prior history of mental illness. The client reported difficulty communicating with coworkers and family members, contributing to feelings of frustration, low mood, and occupational disengagement. His spouse reported increased temper outbursts, social avoidance, and verbal passivity during household interactions.

Psychosocial history indicated limited formal education (up to 8th grade) and low socioeconomic status. The client resides in a semi-urban area with limited access to audiological services. Family support was present but strained due to communication barriers

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and emotional distancing. There was no reported history of substance use, head trauma, or significant medical comorbidities apart from the recent hearing impairment.

Medical documentation confirmed moderate-to-severe bilateral sensorineural hearing loss. The client was awaiting fitting of hearing aids through the government disability scheme at the time of intake. He was referred for psychological intervention by the attending ENT specialist due to emerging behavioral and emotional symptoms suggestive of an adjustment reaction.

Assessment and Diagnosis

A preliminary psychological evaluation was conducted during the intake phase to determine the client's current mental state and psychosocial functioning. The assessment process involved clinical observation, an unstructured interview, and a Mental Status Examination (MSE).

Mental Status Examination (MSE)

The client appeared his stated age, was appropriately groomed, and exhibited cooperative but subdued behavior. He maintained intermittent eye contact and demonstrated reduced psychomotor activity. Speech was low in volume, with delayed latency and minimal spontaneity, attributed partially to his bilateral hearing impairment. Affect was constricted, and mood was subjectively reported as “sad and frustrated.” Thought processes were coherent and goal-directed, with no signs of delusions, hallucinations, or formal thought disorder. Cognitive functions (orientation, memory, attention) appeared grossly intact. Insight into the psychological impact of his hearing loss was limited, and judgment was observed to be fair.

Provisional Diagnosis

Based on the clinical presentation and temporal association between the onset of hearing loss and the development of affective symptoms, the client was provisionally diagnosed with:

- ***Adjustment Disorder with Depressed Mood*** **(F43.21), as per the** ***Diagnostic and Statistical Manual of Mental Disorders*** **(5th ed., text rev.; DSM-5-TR; American Psychiatric Association, 2022).**

Audiological findings and ENT records were noted as contributing factors to the psychosocial distress, necessitating an integrative management plan involving both mental health and rehabilitative services.

Therapeutic Approach

An eclectic, phase-based intervention model was implemented, integrating Cognitive Behavioral Therapy (CBT), Supportive Psychotherapy, and Psychoeducational techniques,

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tailored to the client's needs within the constraints of a district hospital setting. The therapeutic goal was to facilitate emotional adjustment to hearing loss, reduce depressive symptoms, and restore adaptive functioning in occupational and interpersonal domains.

Acquired hearing loss in adulthood often precipitates a grief-like response, accompanied by identity disruption, loss of autonomy, and deteriorating interpersonal communication (Kyle et al., 2024). CBT was selected for its empirical support in treating depression and adjustment-related issues, while Supportive Therapy allowed space for emotional ventilation and alliance-building in the early stages. Psychoeducation played a critical role in improving insight and reducing internalized stigma around both hearing impairment and emotional distress (Timmer et al., 2024).

Modifications for Accessibility

To accommodate the client's moderate-to-severe bilateral hearing loss, the following modifications were incorporated:

- Use of written prompts and visual aids for key psychoeducational content.
- Slowed pace of speech and increased use of gestures during sessions.
- Allowing the client's spouse to support communication when appropriate.
- Ensuring a distraction-free, quiet setting during sessions.

Phase I: Engagement and Support (Sessions 1–3)

The initial phase focused on building rapport, validating the client's emotional responses, and assessing readiness for change. Supportive psychotherapy principles were used to provide a non-judgmental space where the client could express frustration, anger, and helplessness. Psychoeducation was provided on the psychological impact of sudden hearing loss, emphasizing the normalcy of grief reactions and the brain-behavior interplay in depression.

Phase II: Cognitive Restructuring and Behavioral Activation (Sessions 4–8)

The second phase employed CBT techniques targeting negative automatic thoughts such as *"I am useless now,"* and *"No one wants to talk to me anymore."* These beliefs were examined through collaborative cognitive restructuring. Simultaneously, a graded behavioral activation plan was introduced, involving structured re-engagement in routine tasks, walks with his spouse, and re-initiation of limited social interaction at the worksite.

Daily mood logs and a simple activity-monitoring chart were used to track behavioral changes. Emphasis was placed on mastery and pleasure-based tasks to enhance self-efficacy and motivation.

Phase III: Coping Skill Consolidation and Family Involvement (Sessions 9–12)

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The final phase focused on consolidation of gains and strengthening adaptive coping mechanisms. Sessions incorporated:

- Training in basic problem-solving skills.
- Assertiveness building using role-play and written scenarios.
- Involving the spouse to co-create a home environment that supports emotional and communicative needs.

A relapse prevention plan was formulated collaboratively, emphasizing early identification of mood dips, scheduling pleasant events, and routine follow-up with audiology services.

Therapeutic Outcomes

The therapeutic intervention resulted in significant improvements across multiple domains of functioning. One of the primary areas of change was the client's emotional adjustment to their hearing loss. At the beginning of therapy, the client experienced intense feelings of frustration, helplessness, and sadness related to their sudden sensory impairment. However, through the integration of supportive psychotherapy, psychoeducation, and cognitive restructuring, the client gradually reported a reduction in these negative emotional states. The psychoeducational component of the intervention helped the client understand the psychological impact of hearing loss, normalizing their grief reactions and allowing them to process the loss in a healthy way.

The reduction in depressive symptoms was another key outcome of the therapy. Throughout the course of treatment, the client's depressive symptoms significantly decreased, as evidenced both by self-reports and mood logs. Cognitive Behavioral Therapy (CBT) was particularly effective in addressing the negative automatic thoughts that had previously dominated the client's thinking. These thoughts were systematically challenged and replaced with more adaptive, realistic cognitions. Additionally, the graded behavioral activation plan, which encouraged the client to re-engage in meaningful activities, contributed to a noticeable improvement in mood and motivation.

In terms of coping, the client made notable strides in developing more adaptive strategies to manage the emotional and social challenges of living with acquired hearing loss. The incorporation of coping skills training, problem-solving strategies, and assertiveness training helped the client improve their ability to navigate difficult situations. The client reported feeling more competent in managing their emotional responses, particularly in interpersonal situations where communication difficulties had previously led to frustration and isolation. The family involvement in the final phase of therapy further bolstered the client's

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coping skills, as they were able to co-create a more supportive home environment with their spouse.

Significant improvements were also observed in the client's social and occupational functioning. As therapy progressed, the client began to re-engage in social activities and workplace interactions. The behavioral activation plan helped the client gradually reintegrate into these settings, beginning with small steps such as taking walks with their spouse and initiating brief social interactions at work. These changes were critical in reducing the client's sense of isolation and improving their overall sense of social connectedness. The involvement of the spouse in therapy further enhanced the client's communication at home, allowing them to feel more supported and less isolated in their emotional struggles.

Finally, family dynamics were positively impacted by the intervention. Involving the client's spouse in the therapeutic process helped create an environment that was more conducive to emotional expression and effective communication. The client reported that their relationship with their spouse improved significantly, as they felt more understood and supported. This collaborative approach played a crucial role in the client's overall success in therapy, as it contributed to a stronger, more supportive family dynamic.

Discussion

This case underscores the significant psychological toll of adult-onset hearing loss, particularly when compounded by socioeconomic disadvantage and limited access to rehabilitative care. The client's depressive symptoms, emotional dysregulation, and social withdrawal reflect patterns observed in recent literature linking hearing impairment with mood disturbances, social isolation, and reduced quality of life (Tsimpida et al., 2022; Jiang et al., 2022). The therapeutic approach was informed by Kyle et al.'s (2024) model, which frames adjustment to hearing loss as a grief-like process involving identity disruption and interpersonal strain. Guided by this framework, the intervention prioritized emotional validation, cognitive restructuring, and behavioral re-engagement. CBT techniques directly targeted the client's maladaptive beliefs around worthlessness and rejection, while supportive therapy provided the empathic grounding necessary for trust-building and emotional expression in early sessions.

Modifications to accommodate hearing loss—such as visual aids, slowed speech, and spousal involvement—were critical in ensuring therapeutic accessibility and engagement, echoing clinical recommendations by Timmer et al. (2024). The integration of psychoeducation also helped normalize the client's emotional responses and reduce internalized stigma, facilitating insight and motivation for change. Overall, the client's progress highlights the

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feasibility and impact of low-cost, contextually adapted psychological interventions in promoting recovery and resilience among individuals adjusting to sensory disability.

Conclusion

This case highlights how adult-onset hearing loss can precipitate a cascade of psychological, relational, and functional disruptions, particularly in under-resourced settings. The client's trajectory underscores the value of early, contextually tailored interventions that integrate emotional support, cognitive restructuring, and psychoeducation. Beyond symptom reduction, therapy served as a bridge to meaning-making, agency, and social reintegration. This case reinforces the imperative for mental health services to not only accommodate sensory impairments, but also to recognize the broader psychosocial dimensions of disability, especially among socioeconomically marginalized populations.

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