Journal of
The Association of Hearing Instrument Practitioners of Ontario

Signal

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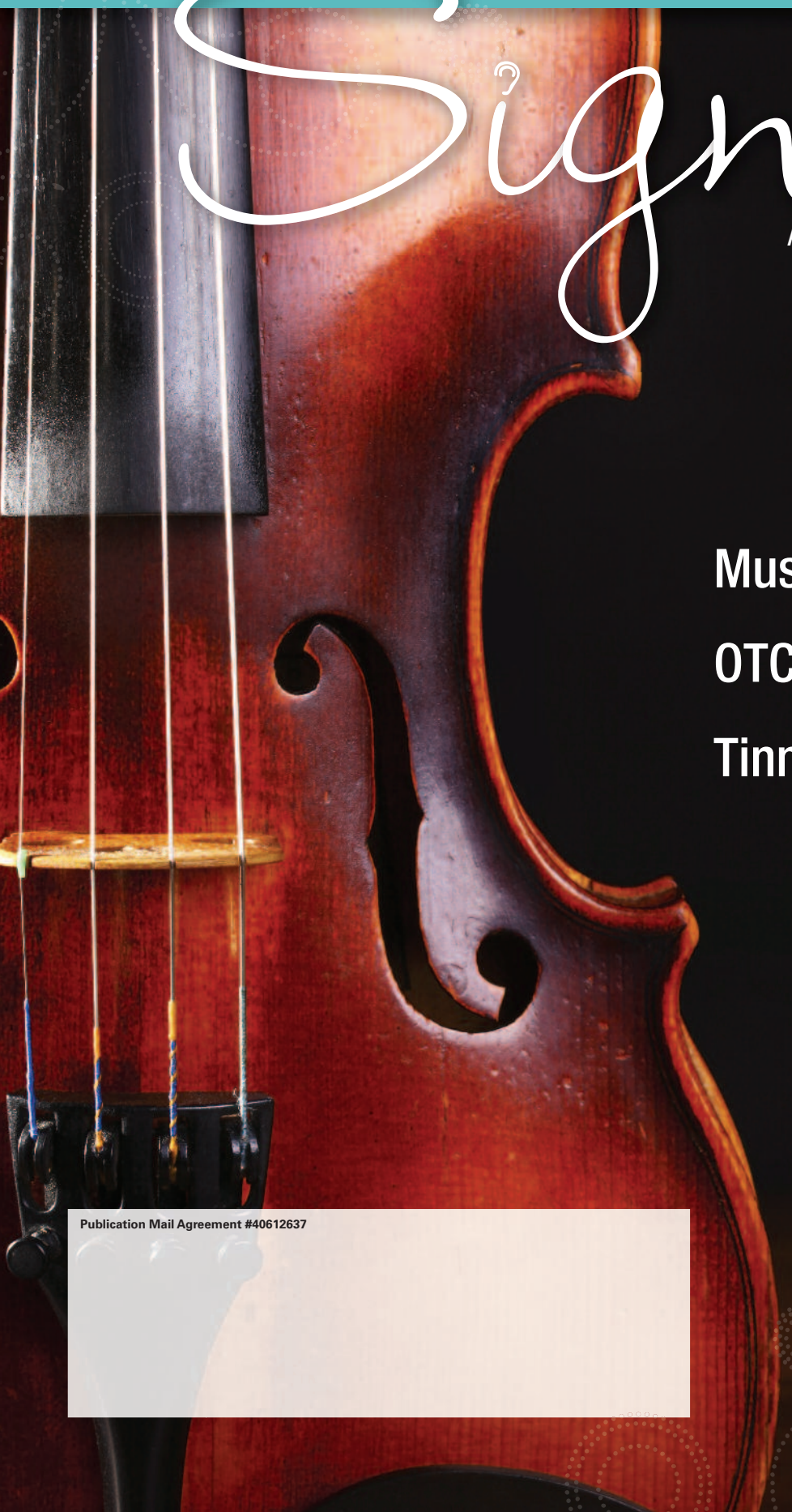

Musical Ear Syndrome

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Tinnitus: A Primer

Publication Mail Agreement #40612637

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Signal is circulated to all hearing instrument practitioners, contributing hearing aid manufacturers and suppliers, as well as Ontario otolaryngologists, audiologists, and other interested individuals.

The mission of the Association of Hearing Instrument Practitioners of Ontario is to represent and guide its members in their practice which include, the testing, selecting and fitting, and dispensing hearing instruments and associated devices in the best interest of the hard of hearing, and may include the removal of cerumen from the external ear canal. Membership is available to hearing instrument practitioners or to those who have an interest in the hearing instrument profession.

Signal is the official journal of AHIP, the professional association of Hearing Instrument Practitioners of Ontario, incorporated in 1988 for the purpose of ensuring quality care for the hard of hearing. *Signal* presents technical and trade information to assist hearing instrument practitioners to better serve the hard of hearing.

Manuscripts
Researchers, practitioners, and others are invited to submit articles and papers for publication. *Signal* assumes no responsibility for return of unsolicited materials, and is not guaranteeing that every article of paper submitted will be published in *Signal*.

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AJF Andrew John Publishing Inc.

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FEATURES

Editor's note: We inadvertently left out the photo credit for the terrific pictures from the AHIP Conference that appeared in the last issue of Signal. It should have been attributed to Lisa Simmonds Taylor and Sharon A Canzi. Sharon Canzi Photographics. We apologize for the error.

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PEOPLE FIRST

Dear Members,

In November 2012 over 3000 family physicians from across Canada will be meeting for their Annual Family Medicine Forum in Toronto and AHIP will be there!

Your entire board has been working diligently in organizing AHIP's presence for this very important and beneficial event for our members. We are excited and ready to represent our members as being highly educated and professional hearing health care providers in Ontario.

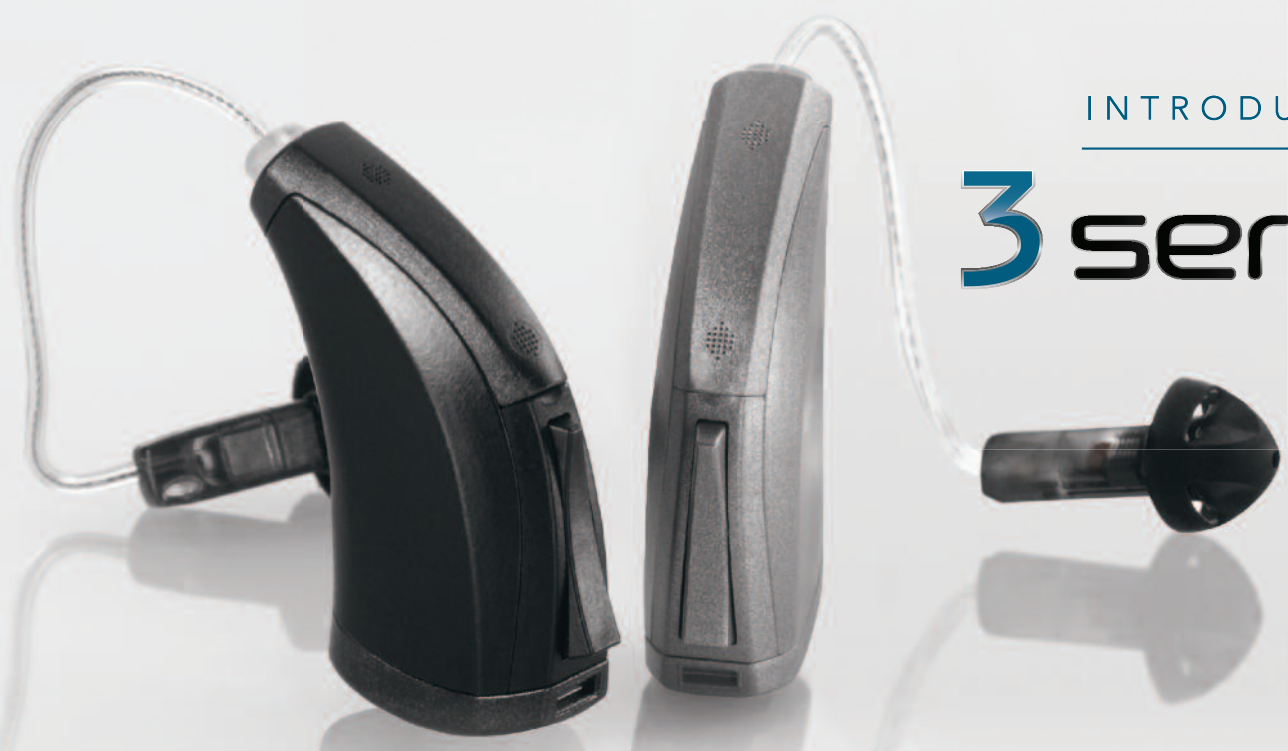
On another note, as you read through this *Signal* edition you will also notice in an article written by our own member Adam Perrie one of the efforts AHIP performs behind the scenes on behalf of the membership as well as the protection of the hard of hearing in Ontario.

AHIP continues to represent the membership and public by addressing concerns that affect all of us.

We appreciate your support and your feedback and look forward to growing our Association by uniting with other hearing healthcare organizations not only in Ontario and Canada but around the world!

Respectfully Submitted,

Vivienne Saba-Gesa, H.I.S.
AHIP President



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Dear Members,

As mentioned in your most recent membership mailing, Vivienne and I attended the International Hearing Society (IHS) Convention & Expo in Arizona, September 20–22, 2012.

We were extremely impressed with the venue, quality educational seminars, organization and the very welcoming atmosphere.

While attending the Chapters Leadership Conference, Licensing Board Conference, Annual General Meeting and various seminars it became abundantly clear to us that the collaboration IHS has formed with other hearing health care professions and organizations is growing and developing. These relationships help form alliances and can strengthen the resolve to better protect and care for the hard of hearing. Examples of organizations in which collaborate efforts exist are with the American Academy of Otolaryngology – Head and Neck Surgery , the Hearing Industries Association and the Better Hearing Institute.

Also, it was quite heart-warming when the National Board for Certification in Hearing Instrument Sciences (NBC-HIS) honoured Dr. Jerome C. Goldstein MD, FACS, FRCSEd for his major contributions to NBC-HIS and the hearing health industry, including being a public member of the NBC-HIS, Executive Council since 2000.

The International Hearing Society clearly has a new vision and focus. We look forward to ongoing communication and collaboration.

Respectfully Submitted,

Joanne Sproule
Executive Director

Happy fall to all! Hope you had a great Thanksgiving weekend and lots of reasons to be thankful. At the moment I am most thankful for the talented folks that are part of our association. Take Adam Perrie for example. Did you know that he is a writer and a detective? Read on and you shall discover this yourself. And how about our newest member on the board of directors, Scott Laidman? He has written a beautiful piece on his experience living with hearing loss that is sure to move you. We are fortunate to have so many members that share their talents with us.

In addition to our member contributions we have the first instalment of articles to be contributed by John Niekraszewicz. You many recognise this name as he is the gent that is responsible for the AHIP Health and Dental Benefits Plan. John has just as many letters after his last name as he has in it so it is no surprise that he is a valuable resource. Thank you John for offering to provide a regular advice column. Finally, I found an article on Musical Ear Syndrome. Although it is not a new discovery, it is a fascinating one. I would be interested in hearing any first hand experiences our members may have had with this phenomenon.

Lisa Simmonds Taylor, BA, H.I.S.
AHIP Secretary, Editor-in-Chief

Musicians, Music Lovers and Military Maintain Greatest Risk for Tinnitus

The prevalence of tinnitus is no secret in today's society, with – according to the American Tinnitus Association – more than 50 million people in the United States alone suffering from the condition.

At the same time, accurately diagnosing tinnitus can be challenging, says Curtis Amann, vice-president of marketing and sales for Neuromonics, Inc. Described as ringing in the ears when no external sounds are present, tinnitus symptoms are different for each person, Amann said, and can include ringing, buzzing, humming, roaring, or whistling sounds.

Understanding the populations that are at greatest risk for tinnitus can help individuals determine whether they may have the condition. At-risk individuals also can try and lessen exposure to the conditions that may have caused, or are contributing to, their tinnitus.

Military

Usually brought on by exposure to loud noise, tinnitus is especially significant in the military. More than 34% of returning veterans from Iraq and Afghanistan suffering from the condition, now the No. 1 service-connected disability for veterans from all periods of service. Since 2005, the number of veterans receiving service-connected disability for tinnitus has increased by at least 15% each year, according to the American Tinnitus Association. The total number of veterans awarded disability compensation for tinnitus at the end of 2010 surpassed 744,000.

Musicians and Music Lovers

Any kind of music, ranging from classical to heavy metal, can be too loud. Performers, audio engineers and listeners of all types of music are at risk for noise-induced tinnitus. As technology helps weave music into almost every facet of life, the danger of music that is too loud continues to increase. Individuals will not begin to suffer from tinnitus in the short run; the condition arises as a cumulative effect of noise over a period of years.

Individuals Who Work Near Loud Equipment

Those who work, or who have previously worked, with aircraft, or loud machinery or other equipment constitute another significant at-risk group. Despite better regulations to control noise levels in the workplace, and hearing protection devices, continual exposure over time to noisy environments may contribute to the incidence of tinnitus.

Seniors

Tinnitus is prevalent as one of many age-related hearing problems in the older population. Causes likely include the cumulative effect of loud noises and general noise pollution over the years.

"We live in an extraordinarily noisy world that is getting noisier by the day," says Amann. "Tinnitus can strike anyone, at any time, but for individuals particularly at risk, it is important to be aware of the condition, and to take precautions to mitigate levels of noise exposure."

http://www.healthyhearing.com/content/news/Tinnitus/Ringing-in-ears/50292-Musicians-music-lovers-and-military-maintain-greatest-risk-for-tinnitus

Boomers Benefit from hearing Aids As They Stay In the Workforce Longer

Let's face it. The Great Recession put a kink in many American's retirement plans. Combine that financial blow with the general uncertainty regarding Medicare and the future cost of private health insurance.

As a result, more boomers are staying in the workforce longer. In fact, between 2006 and 2016 the number of older people in the workforce is expected to soar, according to the U.S. Bureau of Labor Statistics (BLS). Workers between the ages of 55 and 64 are expected to increase by 36.5%; the number of workers between 65 and 74 is expected to climb by 83.4%, and even the number of workers who are 75 and older is expected to grow by 84.3%. By 2016, the BLS says, workers age 65 and over are expected to make up 6.1% of the total labor force – a steep jump from their 3.6% share in 2006.

So what does this mean for individuals? It means people need to do what they can to age productively. It means they need to take charge of their health - including their hearing health – so they can maximize their chances for success on the job. Along with maintaining a healthy lifestyle, it's important that boomers routinely get their hearing checked – and that they address any hearing loss so it doesn't undermine their efforts on the job or their quality of life.

Gone are the days of ignoring hearing difficulties. There are no more excuses. And given the technological advances of modern hearing aids, and the compelling data that illustrate the downside of leaving hearing loss unaddressed, there's only one reasonable course of action. Maturing workers should be getting their hearing checked. And if there is hearing loss, they should discuss with their hearing health care provider whether or not hearing aids could help.

Consider this: More than 34 million Americans suffer from hearing loss - about 11 percent of the U.S. population – and 60% of them are below retirement age, according to the Better Hearing Institute (www.betterhearing.org). Research shows that the use of hearing aids reduces the risk of income loss by 90 to 100% for those with milder hearing loss, and from 65 to 77% for those with severe to moderate hearing loss. Those with moderate-to-severe hearing loss who use hearing aids are twice as likely to be employed as their peers who do not use hearing aids. And three out of four hearing aid users report improvements in their quality of life due to wearing hearing aids. The vast majority of people with hearing loss, in fact, could benefit from hearing aids.

More good news: Today's employers recognize the changing demographics of the modern aging workforce and increasingly are making efforts to hold onto their older workers. Employers value the experience that mature employees bring to the job - along with the strong work ethic and other positive attributes that older workers tend to possess.

More and more companies, in fact, engage in workplace wellness programs to help keep their employees in good health. And hearing health – including hearing checks – is increasingly included in these programs.

"Never before has good hearing been so important – or so attainable," says Dr. Sergei Kochkin, executive director of the Better Hearing Institute. "When people with even mild hearing loss use hearing aids, they improve their job performance, increase their earning potential, enhance their communication skills, improve their professional and interpersonal relationships, and stave off depression.

"I urge anyone planning to stay in the workforce longer to take that first, most critical step to optimizing your hearing health and enhancing your chances for career success by taking a confidential, online hearing check at www.hearingcheck.org. It will help you determine if you may need a more thorough hearing test by a hearing health professional," Kochkin continues. "Your hearing health and continued job success are within your control."

http://www.betterhearing.org/press/articles/Boomers_helped_by_hearing_aids_in_workplace_AR A.cfm

Commentary: The Dollars and Sense Addressing Hearing Loss in the Workplace

By Sergei Kochkin, PhD, Executive Director of the Better Hearing Institute

Hearing loss doesn't win many headlines. Nor does it win much time in the doctor's office. But maybe it should. And perhaps America's employers should be the first to listen up. Consider this:

The majority of people with hearing loss are still in the workforce. That's more than 20 million Americans.

Workers with hearing loss are five times more likely to take sick-days due to severe stress than their co-workers without hearing loss. Perhaps this is because most people with hearing loss don't get tested and treated.

Hearing loss is linked to a three-fold risk of falling among working-aged people (40 to 69) whose hearing loss is just mild. Falls and fall-related injuries cost billions in healthcare costs in the United States each year.

Unaddressed hearing loss often leads to isolation, anxiety, and depression. For employers, the estimated annual economic burden of depression, sadness, and mental illness is $348.04 per employee. More absences from work are due to depression, sadness, and mental health issues than any other illness.

Hearing loss is linked to heart disease. Some researchers even hypothesize that hearing loss could be an early warning against heart disease-America's number one killer- potentially presenting an opportunity for early intervention, better outcomes, and contained healthcare costs. Heart disease is a huge expense for American businesses, tallying $368.34 per employee per year when averaged across all employees.

Perhaps the most eye-opening statistics for workers themselves to consider, however, are these:

People with untreated hearing loss lose up to $30,000 in income annually, depending on their degree of hearing loss. That's a loss to society of $26 billion in unrealized federal taxes; and an estimated aggregate yearly income loss of $176 billion due to underemployment.

People with hearing loss who do not use hearing aids are nearly twice as likely to be unemployed as their peers who use hearing aids.

Moving people to acknowledge and address their own hearing loss has long been an uphill battle, largely due to the fear that people have of growing or appearing old. And because most hearing loss progresses gradually-and is not acutely life-threatening-people tend to put off dealing with it. Too often, people ignore their hearing loss for far too long, allowing it to take its toll on their quality of life, cognitive function, mental and physical well-being, relationships, and their effectiveness and opportunities in the workplace. Unfortunately, fewer than 15% of people are screened for hearing loss by their doctors during their annual physical exams.

For both workers and employees, the stakes on hearing health are high. Over the past generation, hearing loss grew at 160% of the U.S. population growth. We now live in an age in which MP3 players, ear buds, and loud recreational activities abound. What was once considered age-related hearing loss is being seen more frequently at younger ages. American workers are losing their hearing earlier on in their careers. And America's baby boomers are aging. What's more, as global financial conditions remain uncertain, people are staying in the workforce longer, delaying retirement. The financial and human resource risks of leaving hearing loss unaddressed in the workplace have never been so high.

The good news is that the vast majority of people with hearing loss can be helped with hearing aids. Quality of life improves for three out of four who use hearing aids. And for people with milder hearing loss, studies have shown that the use of hearing aids reduces the risk of income loss by 90 to 100 percent, and from 65 to 77% for those whose hearing loss is severe to moderate.

We know from experience that good communication enhances performance, productivity, job satisfaction, and results. Simply put: unaddressed hearing loss is an unnecessary and not insoluble barrier to good communication.

Employers have a responsibility to create working environments in which individuals with hearing loss are unafraid to acknowledge and address their hearing impairment. By encouraging workers to have their hearing checked as part of the company's workplace wellness program, those with hearing loss will be far less likely to hide it, and will be far more likely to seek treatment. Together, the employer and employee can identify the most appropriate accommodations to help ensure that a worker's hearing loss does not interfere with job performance, productivity, safety, quality of life, morale, opportunities, or success in the workplace.

http://www.betterhearing.org/press/articles/Addressing_Hearing_Loss_in_the_Workplace.cfm

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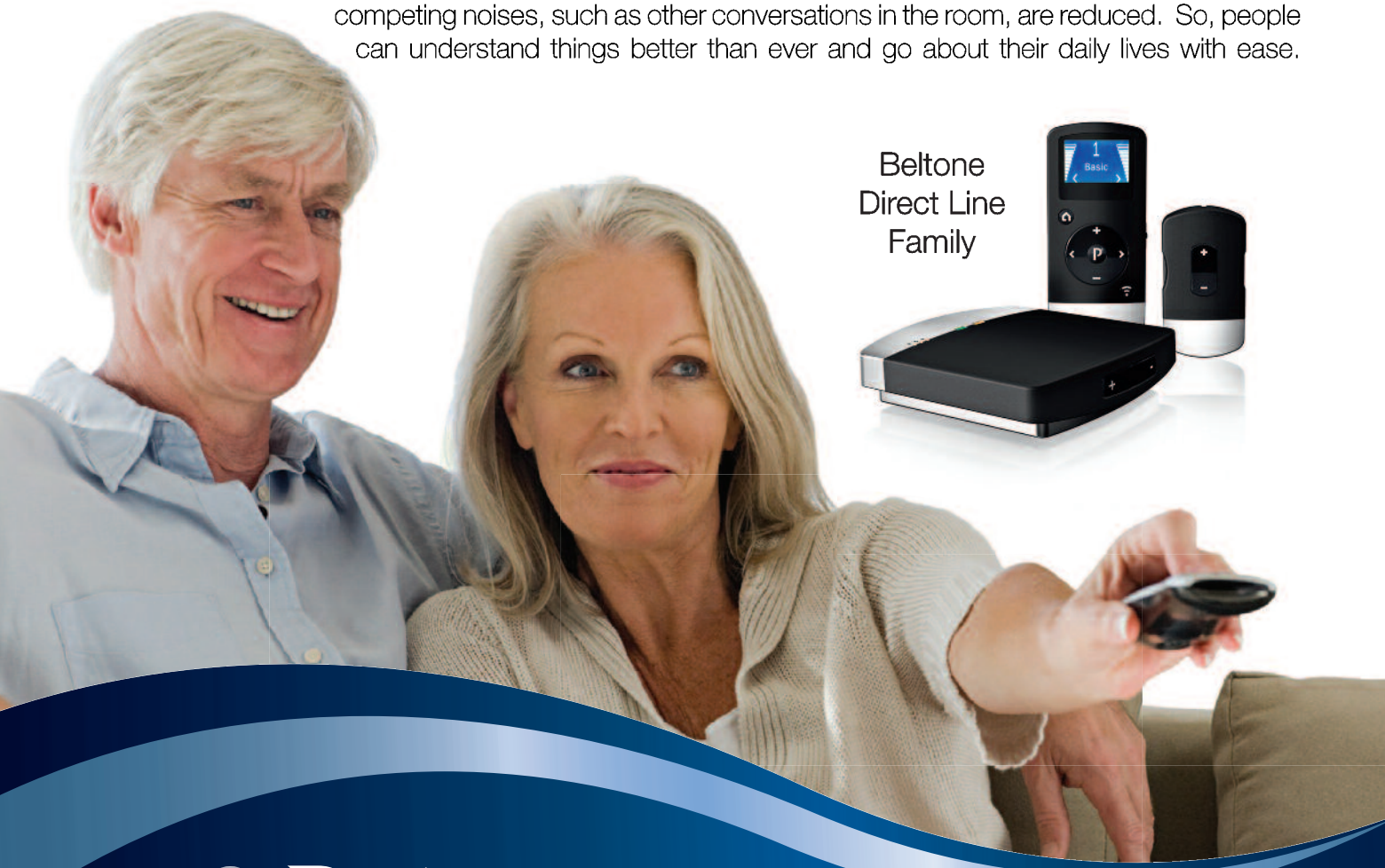

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Musical Ear Syndrome

Part I: The Phantom Voices, Ethereal Music, and Other Spooky Sounds Many Hard of Hearing People Secretly Experience

Marilyn woke with a start, her heart pounding. It was the middle of the night. "I thought people were calling to me," she explained. "I became truly frightened when I realized that I was deaf and should not be able to hear voices."

"My wife hears music that is not there," Harry writes. "The first song she heard was *Silent Night* sung by a very good choir of mostly men. It came in quite loud. A day later it was the *Vienna Waltz* over and over again so clear it was like being at a musical production."

"I would often lie half awake in the quietness of the early morning and hear a phantom radio," Dick recalls. "A guy would be talking like they did in the 50s. Kind of a monotone voice and all the advertisements like they did back then. It always sounded so real."

"Late at night when I don't have my hearing aids on," Carolyn relates, "I am absolutely sure I hear trucks and bulldozers working right outside our bedroom windows. We are the only ones living on our little country lane. There's no traffic of any kind outside my bedroom windows. My husband swears there are no noises at all."

"Years ago," Sherry remembers, "when my dad would take me flying in his little two-seater wind-knocker airplane, I used to hear strange music. The

music sounded like the full Mormon Tabernacle Choir. Since I was quite young, I thought it was angels singing."

Julie's father-in-law mainly hears loud music when alone in his apartment, oftentimes in the middle of the night. Julie explains, "He has taken to knocking on the downstairs landlady's door at 3 A.M. telling her to turn the music down. I have been with him a few times when he heard the music, but I couldn't hear a thing."

"I was afraid I was going nuts when I thought I was hearing things in my head after my CI surgery," Heather remembers. "On the morning after the surgery, I was hearing what sounded like music from a radio. I heard that every day from my surgery until I was hooked up. It almost drove me nuts. Yet, I never said one word to anyone about it because I didn't want them to think I was crazy."

Janet explained, "My mother-in-law confided in me about hearing music loud and clear at various times of the day, but frequently when she goes to bed. Two doctors now have basically ridiculed her and said they'd never heard of such a thing. My mother-in-law is at the end of her rope. She is even accusing her husband of trying to drive her crazy by playing this music. As you can imagine, this is very difficult on their marriage."

What do these people have in common? They all hear strange phantom sounds that no one else hears. They are also hard of hearing. Nor are they alone. Thousands of other hard of hearing people "hear" similar phantom sounds, yet they never tell a soul because they are afraid of the dreaded "H" word – hallucinations. The very word conjures up visions of phantom voices, padded cells and people in white coats talking in hushed tones. This is because almost everyone associates "hearing voices" with "going crazy" and mental illness such as schizophrenia. It's time to dispel such myths.

What Exactly Are Hallucinations?

According to *Stedman's Medical Dictionary*, hallucinations are "the apparent, often strong, subjective perception of an object or event when no such stimulus or situation is present." More simply put, hallucinations are where your brain perceives that something is happening even though your five senses have not received any direct stimulus.

Hallucinations may be visual (seeing), auditory (hearing), olfactory (smelling), gustatory (tasting) or tactile (feeling). Therefore, hallucinations are simply seeing, hearing, smelling, tasting or feeling sights, sounds, doors, tastes, or sensations that no one else around you perceives.

Although hallucinations may occur with any of the five senses, auditory hallucinations are by far the most common kind of hallucination. A person is hearing auditory hallucinations when he or she hear noises, music, sounds or voices that no one else hears because these phantom sounds are being generated in the person's brain, not externally.

Two Kinds of Auditory Hallucinations

Not many people know this, but there are actually two classes of auditory hallucinations – psychiatric auditory hallucinations, and non-psychiatric auditory hallucinations. People with mental illnesses often experience the former, while hard of hearing people often experience the latter.

Here is an example of a psychiatric auditory hallucination. Elyssa explained, "Lately I've been hearing voices. I don't know where they come from but they are loud and clear. Last week, for example, I was sitting in class when this voice told me that the boy sitting behind me was planning to attack me after school. I jumped out of my seat and began to scream obscenities at him. He denied everything, of course, so I punched him in the face and broke his nose."

As you can readily see, this example is vastly different from the auditory hallucination stories mentioned at the beginning of this article – the kind many hard of hearing people typically experience. These non-psychiatric auditory hallucinations have nothing whatsoever to do with mental illness, but are a symptom of something not working quite right in the auditory circuits in our brains.

If you are hearing phantom sounds, how can you tell which of hallucinations you are experiencing—

whether psychiatric or non-psychiatric? Although I am not a psychiatrist, here are two "rules of thumb."

1. People who experience psychiatric auditory hallucinations generally hear **voices**, whereas people who experience non-psychiatric auditory hallucinations mostly hear **music** or singing, rather than just plain voices.

2. People who experience psychiatric auditory hallucinations generally hear clear and distinct voices either talking **to** or **about** them, and these voices may engage the person in conversation. Consequently, the content is of a **meaningful personal** nature.

In contrast, people who experience non-psychiatric auditory hallucinations often hear voices that sound vaguely like a radio broadcast or TV program playing in another room. For example, Robert explained, "I get Red Barber calling the game. I can't distinguish the words – but I'm sure that's who is talking." Catherine described her auditory hallucinations as "what sounded like the voice of a radio announcer on a badly tuned radio station."

These phantom sounds do not contain any information of a meaningful personal nature. These voices neither talk to the person, or about them, nor do they engage them in conversation.

Characteristics of Auditory Hallucinations

Non-psychiatric auditory hallucinations (hereinafter referred to simply as auditory hallucinations) comprise a wide range of sounds, ranging from simple to complex. **Simple** sounds are single, unmodulated sounds such as the various tinnitus sounds (ringing, roaring, buzzing, hissing, rumbling, etc.) millions of people hear. In fact, tinnitus is the most common kind of auditory hallucination.

In contrast, **complex** sounds include multiple, modulated sounds such as tunes, singing, music and voices. These are the kinds of sounds that people have traditionally considered auditory hallucinations. Many people have mistakenly called these sounds "musical tinnitus."

Depending on their clarity, phantom sounds may be either "unformed" or "formed." **Unformed** auditory hallucinations consist of hearing distorted music, sounds, or voices. These sounds are vague, "fuzzy" and indistinct. For example, Jane described her unformed auditory hallucinations as "like the wind blowing, but with a musical quality, as if someone off in the distance was singing without words." Rachel explains, "The words are never distinct – it's like they are several rooms away." Sarah relates, "I sometimes hear phantom 'radio broadcasts' that I can't quite make out."

In contrast, **formed** auditory hallucinations are where speech, music or singing is so clear and recognizable that people "hearing" such hallucinations can identify the various voices and musical instruments. For example, James explains, "For the past 3 to 4 months I have had the most calming and repetitive choruses and wind ensembles, usually led by a bass sax and a baritone playing and singing in a low octave, the older Christian hymns and a few oldies from the forties such as, Near the Cross, Amazing Grace, His Eye Is on the Sparrow, and The Star Spangled Banner."

Claudia, who has normal hearing, when describing her auditory hallucinations, wrote, "I hear passages of what sound like Strauss waltzes, Russian symphonies, Italian operas – distinctively enough to identify various instruments, male or female choruses, and the occasional soloist."

Incidentally, many people find their auditory hallucinations begin with clearly formed complete sentences or songs. Later, the repetition of lengthy passages of music may degenerate into short snatches of repetitive phrases or rhythmic patterns, or even into unformed auditory hallucinations that are more like the common forms of tinnitus. Tyler's father's auditory hallucinations followed this pattern. He explained, "My dad's musical hallucinations started out as recognizable songs (*Battle Hymn of the Republic* for 2 weeks, then started changing to a variety of other songs, *The Music Man, Ride of the Valkyries*, etc.) then turned into unrecognizable orchestral or vocal-like sounds".

The Need for a New Name – The Fear Factor

Unfortunately, the general public immediately associates **all** auditory hallucinations with mental

illness. For example, if I say I hear non-psychiatric auditory hallucinations, typically you will zero in on the two words “psychiatric” and “hallucinations” – and immediately think I am crazy.

As a result, few people have the courage to admit they are hearing non-psychiatric auditory hallucinations for this very reason. For example, Cheryl explained, “I was afraid I was going nuts. I never said one word to anyone about the strange music I was hearing because I didn't want them to think I was crazy.”

Sharing with family members often elicits a similar response. Anna declared, “All my family believe I am nuts because I told them I hear music every waking moment.”

Because of this fear factor, many people describe their auditory hallucinations in terms such as “musical tinnitus” to avoid using the word “hallucinations.” You see, we don’t typically think people with tinnitus as hallucinating or being nuts, do we?

Obviously, there is a real need for a new term to describe non-psychiatric auditory hallucinations – a name that has no negative connotations associated with it whatsoever, and one that does not include either the words “psychiatric” or “hallucinations.”

Since the vast majority of people who experience auditory hallucinations hear some sort of phantom music or singing, I named this condition **Musical Ear Syndrome**. Not only does it not have any negative connotations, it almost sounds like it might be something good to have – like having an ear for music or having perfect pitch.

For example, when I say, “I’ve got Musical Ear Syndrome,” the first thing that comes to your mind is **not** that I’m crazy. You see, there is no stigma attached to the term to start with. You are left feeling neutral, or even slightly positive, towards this term, or you query with an open mind, “Music Ear Syndrome – what’s that?”

Since I coined the term Musical Ear Syndrome or MES for short back in 2004, I have found that people are far more willing to openly talk about the phantom sounds they “hear.” In fact, the last time I did a search on Google for the phrase “Musical Ear Syndrome” (in quotes) I came up with more than 11,700 websites that now use this term!

Musical Ear Syndrome is Not New

Musical Ear Syndrome has been around for a long time. Only the name is new – not the phantom experiences themselves. For example, composer Robert Schumann heard auditory hallucinations towards the end of his life. At night, he heard musical notes and believed that he heard an angelic choir singing to him. He also heard the music of Beethoven and Schubert. He jotted down the music in February, 1854 and called it the Theme (WoO, 1854). He said he was taking dictation from Schubert's ghost.

Definition of Musical Ear Syndrome

I define Musical Ear Syndrome as hearing non-tinnitus phantom sounds (that is, auditory hallucinations) of a non-psychiatric nature, often musical, but also including voices and other strange sounds.

Tinnitus vs. Musical Ear Syndrome Sounds

Once we throw out psychiatric auditory hallucinations, we are still left with two basic kinds of phantoms sounds – tinnitus and Musical Ear Syndrome sounds. Here's how to tell them apart.

Tinnitus sounds are **single, simple** (unmodulated) sounds such as ringing, buzzing, hissing, roaring, clicking, humming, rushing, whooshing droning and kindred sounds. In contrast, Musical Ear Syndrome sounds include **multiple, complex** (modulated) sounds such as singing, music and voices.

The Most Common Musical Ear Syndrome Sounds

Did you ever wonder what are the most common kinds of MES songs people hear? The truth is that hymns, Christmas carols and patriotic music comprise just over half of all the MES sounds people hear (52% combined).

One lady related, “My 66-year-old mom lost almost all her hearing two months ago. The last three days (this was written on December 28th) she keeps hearing *Silent Night* and *Oh, Come All Ye Faithful*

over and over again. It gets so loud that she can't sleep. She has tried to make it go away but can't. She says that it is just beautiful singing with a full orchestra to boot, but would really like some sleep."

As a matter of interest, quite often MES sounds have a seasonal quality – thus people "hear" Christmas carols during the winter season and *The Star Spangled Banner* around the 4th of July. Incidentally, while Americans often hear *The Star Spangled Banner,* Canadians typically hear *God Save the Queen* or *O Canada*, and Australians often hear *Waltzing Matilda!*

How Common Is Musical Ear Syndrome?

Because so few people admit to hearing phantom sounds, researchers, up to now, have considered Musical Ear Syndrome (under whatever name they call it) very rare. But that is just not true. Musical Ear Syndrome is much more common than anyone seems to realize, and affects significant numbers of hard of hearing people.

Since few people are willing to admit to hearing these phantom sounds, it is difficult to obtain accurate figures. I estimate that well in excess of 10% of hard of hearing people experience these phantom sounds at one time or another.

For example, when I speak to groups of hard of hearing people on this subject, I often ask how many of them have heard such phantom sounds. Since they feel "safe" with me, invariably 10 to 30% of the people present are brave enough to put up their hands. And that is just those willing to publicly admit they have heard such phantom sounds. Others won't even admit that much.

To date, I have collected the stories from more than 1,500 people regarding their MES experiences. This alone tells you how common MES really is.

In Part II we will look at some of the characteristics of people who have of Musical Ear Syndrome, six common triggers of MES and seven ways to help bring it under control.

If you would like to know more about Musical Ear Syndrome you can get a copy of Dr. Bauman's book, Phantom Voices, Ethereal Music & Other Spooky Sounds http://www.hearinglosshelp.com/products/books.htm

Tinnitus: A Primer

By Dr. Phillip Wade, DDS, MD, FRCS(C)

Despite a major breakthrough in tinnitus research by Dr. Pavel Jastreboff in the 1990s with his neurophysiological model, tinnitus (Jastreboff 1990) still remains an enigma, a puzzle yet to be completely solved. What is known to us is that in the majority of cases, tinnitus is related to peripheral hearing loss with the auditory nerve as the final common pathway of sound. Although reduced auditory input may produce tinnitus, the question is why are there tinnitus patients with normal auditory function? (This occurs about 8% of the time.) What other factors predispose these individuals to experience tinnitus?

Tinnitus is a symptom and not a disease and is associated with various risk factors such as advancing age, noise exposure, head injury and certain drugs and medications. It has been described as a phantom auditory perception (i.e., perceived sound in the absence of acoustic stimulation) and it has been classified as subjective – heard by the patient only; or objective – heard by the examiner. The latter may be pulsatile as noted with a vascular tumour in the middle ear, or non-pulsatile heard as repetitive clicking caused by intermittent contraction of the soft palate or the muscles attached to the ossicles in the middle ear (i.e., tensor tympani or stapedius muscles). Approximately 10% of the population experience it. And children are not exempt but do appear to cope better with it. They often assume the noises they hear are completely normal and don't complain.

What causes tinnitus? Tinnitus is often a result of injury to the peripheral auditory system with many central systems involved. One theory that has some merit postulates that the dorsal cochlear nucleus in the brainstem is the generator of tinnitus as a result of peripheral injury to the outer hair cells. (Jastreboff 1995). This may be as a result of the aging process, noise exposure, head injury, or certain ototoxic medications (i.e., the same risk factors associated with tinnitus). The dorsal cochlear nucleus is activated to produce tinnitus when there is a discrepancy between the damaged outer hair cells that play a key role in the motions of the basilar membrane and normal inner hair cells.

Once generated, tinnitus is transmitted to the auditory centre of the brain in the temporal lobe. According to Jastreboff's neurophysiological model, as long as the tinnitus remains constrained to the auditory pathway, as in approximately 80% of the population, they will experience tinnitus but not suffer from it and more readily habituate to it. The suffering is caused by involvement of the sympathetic part of the auditory system and the limbic system – the emotional part of the brain. Once the patient becomes emotionally involved, annoyed, or angry at the tinnitus, the louder it becomes. The more annoyed they get, the more they suffer – neuroplasticity at work. Unfortunately once imprinted in the brain the more difficult it is to habituate to it. Once imprinted, even cutting the auditory nerve will not alleviate it.

A thorough evaluation of the tinnitus patient may indicated whether they are amenable to medical or surgical management. This would include a detailed history to note the nature of the tinnitus which might offer a clue as to the etiology – is the tinnitus intermittent or continuous; unilateral or bilateral; high or low pitched; or if it is pulsatile or non-pulsatile? A low pitched tinnitus may indicate Ménière's disease whereas pulsatile tinnitus in syncrony with the pulse rate, suggests a possible vascular cause. A complete functional enquiry is necessary to enquire as to whether there is a past history of hearing loss, noise exposure, head injury, ototoxic medication, etc. Also, it would be important to note a history of ear infections, eustachian tube dysfunction, previous surgical intervention, or any associated vestibular disturbances.

Following the history, a full head and neck examination is mandatory. Microscopic examnation of the external auditory canal might reveal wax or hair resting against the tympanic membrane producing a repetitive clicking sound. A red hue behind an intact tympanic

membrane may be seen in some otosclerotic patients or an inferior mass on the floor of the middle ear in keeping with dehiscent jugular bulb. It is important to auscultate the head and neck to reveal any vascular abnormalities. Finally, if warranted, a complete otoneurological examination might be indicated to include examination of the cranial nerves and vestibular system.

A full audiological assessment follows along with radiographic imaging, as required. A high resolution CT or MRI or possible angiography may be needed as a diagnostic adjunct for tumors of the internal auditory canal or vascular tumours at the base of the skull. In patients with pulsatile tinnitus carotid doppler (ultrasonography of the carotid arteries) might confirm an obstruction. Blood tests to include testing for vitamin B12 deficiency, lipid abnormalities ,or thyroid abnormalities are rarely helpful.

What options do we have in treating tinnitus? First of all, almost everybody experiences brief periods of tinnitus at times, especially youngsters following loud concerts but fortunately most people are not too concerned about it and often, reassurance will allay apprehension.

Loud tinnitus is less than 10 dB sensation level and even though patients may be experiencing loud chronic tinnitus, many can be easily distracted by everyday noise at work and at play, and complain only about it when in quiet (Dobie 2004). Sleep disturbance is not uncommon. They may have difficulty in initiating sleep with tinnitus or waking up with it, and unable to get back to sleep after. For most patients, it is only a nuisance factor which requires explanation and reassurance to help alleviate the symptom over time.

Unfortunately 20% of patients are suffering from chronic tinnitus. Many, if not most have some predisposing psychological problem (e.g., anxiety or depression). In some, it may start gradually and in others there may be an immediate onset. In the latter group of patients, the onset often occurs at the time of a severe grief reaction (e.g., the loss of a loved one, a failed marriage, loss of a job, etc.). They usually do not make the connection. In the case of the lost oved one, especially if it was due to medical condition, they may become anxious that their tinnitus is possibly associated with the same condition. The more anxious they become, the louder the tinnitus – further increasing their anxiety.

Presently curing tinnitus is an elusive goal. The most successful treatement to date is directed not as much at treating the tinnitus sensation itself, but at the suffering caused by the tinnitus. Counselling, possibly in conjunction with a psychologist and/or support groups, may be extremely helpful. The Tinnitus Retraining Therapy program designed by Dr. Jastreboff is one of several approached that combines the element of counselling with gradual habituation to the sound centrally with the use of sound generators. (Jastreboff and Jastreboff 2000). The sound generators, by partially masking the tinnitus, allow the brain not only to gradually habituate to the white noise but to the tinnitus itself. The drawback is that this is a prolonged process involving wearing the device continually during waking hours over a 12- to 24-month period. The patients therefore have to be very motivated. Success rates of 80% have been reported in the literature for numerous international centres.

Medical treatment when held up to high levels of accountability by randomized clinical trials (RCTs) has been found wanting. Xanax – a benzodiazapine – has been shown on one RCT to reduce tinnitus sensations but drug dependance can be problematic (Johnson et al. 1993). Anticonvulants, antiarrythmics, and various miscellaneous drugs such as melatonin (Roseberg et al. 1998), betahistine (Kay 1981), eperisone (Kitano et al. 1987), etc. have failed on RCTs to demonstrate benefit. Zinc in one RCT in Turkey (Paaske et al. 1991) showed some benefit (a number of these patients were zinc deficient) but no benefit was found on another RCT. Homeopathic medications such as Ginko biloba which has been widely used has failed to show improvement on most RCTs. (Drew and Davies 2001). In other homeopathic remedies there is concern about the consistency of the drug and possible side effects or significant drug interactions. The most successful drug treatment presently is directed towards treating depression and minimizing sleep disturbance. Nortriptyline (an antidepressant) at bedtime has been widely recommended in such patients (Dobie et al. 1993).

Do non drug treatments work? Electrical stimulation if the inner ear, biofeedback, and acupuncture have all been tried with varying degrees of success. Electrical stimulation of the inner ear to suppress tinnitus is not new and various forms of wearable devices have been tried since the nineteenth century but it is the result of coclear implant technology that has been the most interesting. Many patients who have received such implants have noted as a welcome side effect that their tinnitus is reduced. This suppression is likely on the basis of restoring spontaneous activity in the auditory nerve, if indeed it is believed that tinnitus is a result of reduced activity due to some pathological process. Further research is required in this direction.

Biofeedback may have a role to play. It is known that in some patients, their tinnitus may fluctuate on contraction of the jaw muscles. This would suggest some connection between the trigeminal nerve which activates these muscles and the auditory nerve. Reducing muscle tension by the means of biofeedback techniques therefore might reduce tinnitus. Unfortunately, it has been hard to evaluate it since it is difficult to address the placebo effect and, up to date, there is little evidence to support this therapy.

Many patients have tried acupuncture and often report initial success but for this form of therapy the initial success is most likely a placebo effect.

Is surgery an option? This is certainly an option for some patients. Those who have lost hearing due to otosclerosis often complain of associated tinnitus. Surgery for otosclerosis will improve hearing dramatically in 90% of patients but it is a 50/50 proposition for the improvement of the tinnitus. Unfortunately there is a slight chance of making the tinnitus worse. For patients with Ménière's disease and have failed medical treatment, acoustic nerve section, endolymphatic sac surgery, labrynthectomy, and ablation with ototoxic antibiotics through a myringotomy tube, may reduce tinnitus but potentially could make it worse. Approximately 50% of patients who have acoustic neuroma surgery to remove a tumour in the internal auditory meatus pressing on the auditory nerve have also noted a decrease in their tinnitus. Similarly reduction of tinnitus has been noted after a removal of a vascular tumour in the middle ear. Unfortunately in all of the above surgical procedures, hearing loss is a possibility and in some cases, it is guaranteed.

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Over-the-Counter Hearing Aid Sales in Ontario Stopped by AHIP

By Adam Perrie

Over-the-Counter (OTC) sales of hearing aids has long been opposed by AHIP for a variety of reasons. Hearing loss is a medical condition that can be caused by any variety or combination of medical, genetic, and environmental factors. The ability to purchase hearing aids off the shelf enables a patient to ignore potentially serious health issues that could lead to further hearing loss and other potentially very serious health issues.

Furthermore unauthorized "hearing aids" could actually damage a person's hearing and expose them to other uncontrolled and potentially unhealthy materials and situations. In Canada, a hearing aid is a class 2 medical device and must be approved pursuant to the Medical Devices Regulations made under the Food and Drug Act and as well, you cannot advertise hearing aids which have not been approved for sale in Canada.

Also, from the *RHPA, 1991 (Registered Health Professions Act)*

> *Dispensing hearing aids*
> *31. No person shall dispense a hearing aid for a hearing impaired person except under a prescription by a member authorized by a health profession Act to prescribe a hearing aid for a hearing impaired person. 1991, c. 18, s. 31.*
> *(For your personal entertainment have a look at section 33's restriction.)*

As you can see in Ontario, a person or company may not import unregistered devices and sell them as "hearing aids." Additionally you must not dispense a hearing aid without a prescription.

To AHIP's surprise in June I sent a flyer to the AHIP office that proudly proclaimed "Hearing Aids $99.95, Free Trial." The price, of course, catches the eye but the real issue at stake was how these hearing aids were being delivered. A major discount store chain was carrying these products and providing them in one of their stores.

On further investigation I found flyers on the windows of the store advertising the "hearing aids" and once inside we quickly located the "hearing aids" on the shelf above the greeting cards and next to the aisle of kitchen utensils and various knick-knacks.

Posing as the concerned son of a parent with hearing loss I went in and asked for more details. The store was selling four models ranging from $99.99 to $499.99. One model was an in-the-ear piece and the other three models were placed behind the ear. One size fits all describes the fitting process with the ability to change the rubber tips for a bit more comfort. The difference between the low end and high end was described as the low end ones were appropriate for hearing one-on-one conversations in a quiet room and the high end ones were for hearing people 20–30 feet away.

The retailer did ask if my parent had ever had a hearing test and I assured him that no, they hadn't but all the family knew that their hearing was poor. He then happily sold me one.

Significant potential risk of harm lies in selling hearing aids to people who haven't been tested and the results properly interpreted. The fitting of non-registered medical devices also has a fascinating history of providing harm to the public alongside dubious quality.

In this case a patient was sold a "hearing aid" without

In Memorium

Linda Rowe

April 26, 1954 – September 27, 2012
Beloved wife of Earl Earl. Dear sister of Sandy and husband Glenn McLachlan, Shelly and husband John Martin, Kim and husband Dan Marshall. Loving aunt to Candice, Sara, Matt, Curtis, and Spencer and step-mother of Katie and Jill.

Poem of Life

Life is but a stopping place
A pause in what's to be
A resting place along the road
To sweet eternity

We all have different journeys
Different paths along the way
We all were meant to learn some things
But never meant to stay...

Our destination is a place
Far greater than we know
For some the journey's quicker
For some the journey's slow

And when the journey finally ends
We'll claim a great reward
And find an everlasting peace
Together with the Lord

even being present. The patient could have simple treatable cerumen impaction or middle ear infection. Possibly a non-malignant tumour of the 8th cranial nerve would be present. Any of the OMA Red Flag Criteria would have been missed.

There is no way of knowing if the device being sold was made of hypoallergenic plastics, the replaceable dome was of unknown material, and as examined the peak frequency response was 1600 Hz – hardly appropriate for the vast majority of hearing losses we see today.

Follow-up care, verification, and counselling in this delivery model was limited to battery sales and a 30-day warranty.

AHIP rapidly forwarded their research to Health Canada and our legal counsel who constructed a polite concise letter outlining the legal implications of selling non-registered medical devices and violations of the RHPA. At last inspection the retailer had ceased carrying and advertising the product.

AHIP continues to promote and protect the welfare of the hearing impaired. OTC and Internet sales of hearing aids do not have the welfare of the hearing impaired as their goal. Serious health issues could be overlooked and the successful use of hearing aids involves the specialized knowledge that we practitioners have and share with our patients on a daily basis as they travel along their individual path towards better hearing – truly something that can't be bottled, commoditized and sold at discount stores.

Your membership and our strength enables the pursuit of this goal.

My Experience With Hearing Loss

By Scott Laidman

I have lived with hearing loss since the day I was born and it has made my life both challenging and rewarding. My journey started on July 29, 1983 in Hamilton, Ontario. I was born three months premature, very sick, and battling for my life with only a small chance of survival. The doctors worked very hard to ensure I survived and because of them, I can now share my story of hearing loss with you.

After my release from hospital, life as a premature baby was fraught with various medical concerns that my parents handled on a daily basis. By the time I was two years old I was a thriving, healthy, and happy toddler. Coincidently it was at this age that my mother began to see red flags. She suspected that I had a hearing impairment and expressed her concerns to one of the doctors who had aided in my medical care. A simple hearing test near my ear was performed and I had a response which meant I passed the test. No hearing problems were detected. Addressing my mother's concerns that I could not hear, the doctor claimed I was just ignoring her calls because I was so engrossed in my environment.

My mother, however, was not happy with this prognosis and conducted a test of her own. She had my father stand behind me and ask if I wanted some ice cream. I did not respond to his question. He tried raising his voice and still there was no response. It was only when he moved to stand in front of me and asked again that, I excitedly indicated "Yes," I wanted some ice cream. It was at that moment they realized I was lip reading. My parents were in shock and had an even greater shock the day I had my hearing tested by an audiologist at Chedoke Hospital in Hamilton. I was tested using a sleeping brain stem test and the audiologist concluded that I had a bilateral severe hearing loss and would need hearing aids. My parents, not knowing much about hearing loss and hearing aids, would go on to endure many hours learning about my condition.

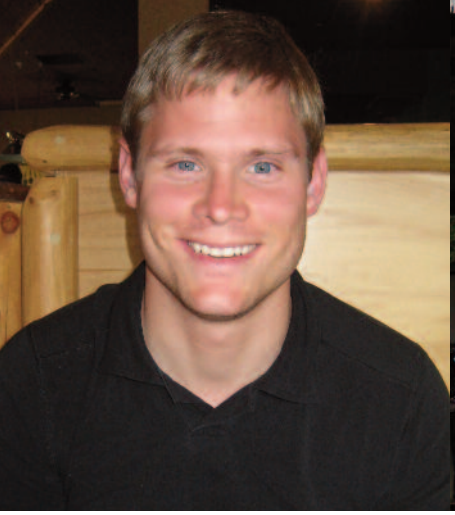
The conclusion reached by professionals was that my hearing loss was the resulting side effect of medication that kept me alive as a premature baby. For the first two years of my life I was not able to hear well, but had learned to read body language and most importantly, read lips. To this day my ability to read lips is still one of my most important compensation tools.

I received my first pair of hearing aids from a local hearing clinic in Hamilton, where the staff of hearing instrument specialists, especially John Tindale, worked with me for the next 21 years. I tried on my first pair of hearing aids on Christmas Day in 1985 with my whole family watching. They were not sure what to expect. My parents put my hearing aids in and I immediately took them out. I hated them! I had been used to a silent world for the first two years of my life and all the sudden I was hearing sounds I had never heard before. I guess I was happy with the silence. I eventually grew accustomed to my hearing aids, but it took many different types of hearing aids, lots of hearing aid adjustments, counselling and a great deal of patience to finally find the right ones.

My transition into the hearing world was not without frustration. My parents remember that I would hit my head on the sidewalk when a car passed by because, I could not stand the noise. They tried so hard to stop me from doing this, but today I have a permanent scar because of it.

Since I did not hear well for the first two years of my life, I missed out on the most important years for speech and language development. To conquer this next challenge, my parents acquired the help of a speech language pathologist. I would go on to endure many hours of speech therapy. My parents, especially my father, would spend roughly two hours a day, five days a week for the next two years, working to improve my speech and listening skills. Their efforts were very successful, but it took many years to build the speech I have today and believe it or not, I still have to work at it.

Although my acquisition of speech went well as a child, I still have great difficulty understanding when



Scott Laidman

Scott Laidman and CHHA Executive Director Robert Corbeil

others speak. The hearing aids I wear help me tremendously, but there are still obstacles, for which I rely a lot on lip reading. My lip reading skill helps me to compensate for the words I am missing. According to my audiogram, my understanding of speech is about 48% in both ears. This means that when I'm not looking at your lips, I'm only able to understand about half of what you are saying. When I lip read, I can understand almost all of what is being said.

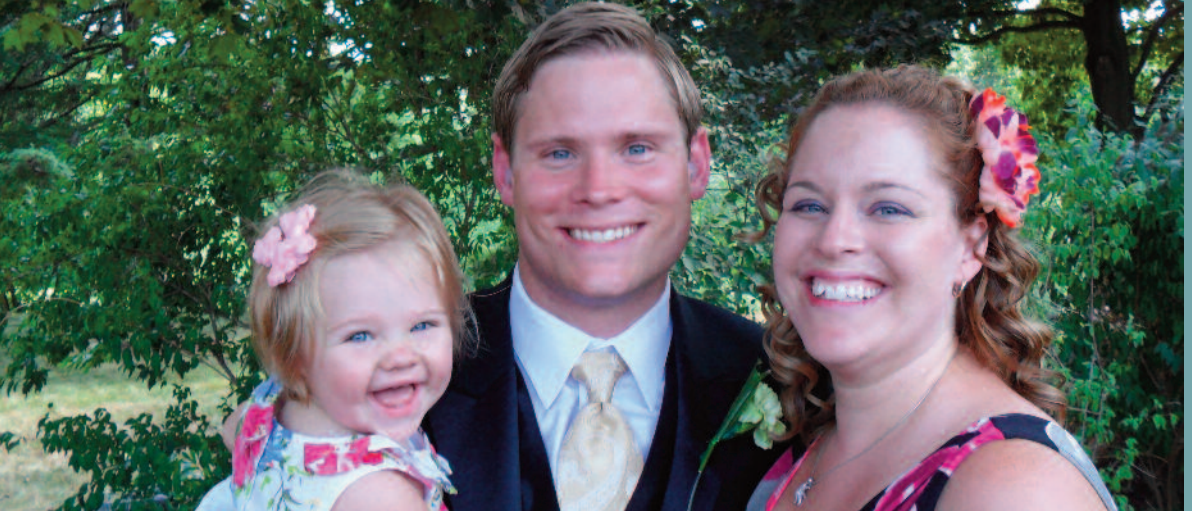
I do get frustrated with my hearing loss from time to time, especially in social environments with large groups of people. For example, family or social gatherings or conferences, where many people may be talking at once can be overwhelming because I have to lip read just to keep up with the conversation. It is nearly impossible to follow multiple conversations at once. Many times I find myself sitting back and not engaging in conversation because it is too much work. It creates both a physical and mental stress that the average person does not go through. That being said, I am a very social person and love to engage in personal one-on-one conversations. I do not allow my hearing loss to "get the best of me" and I remain very positive most of the time.

Elementary school and high school were very challenging times in my life. I had to work twice as hard as my classmates. I used an FM system the day I started elementary school and it was an important part of my education. I had great teachers who believed in me and worked hard to help me by wearing a microphone and that would allow me to hear more clearly. I also remember sitting at the front of the room just so I could see the teacher because I relied on lip reading as well. Socializing at school and making friends was also tough. At the time I was self-conscious and had low self-esteem which made it hard for me to make friends. I did make a few great friends during this time in my life and I am still close with them today. But even now I still have to work on my social skills and occasionally suffer some bouts of low self-esteem.

During my college years, I tried to switch to smaller less conspicuous hearing aids, but this was a terrible choice as, I couldn't hear very well at all. I had to overcome my self- consciousness and use the hearing aids that helped me the best. These tend to be very powerful behind the ear hearing aids with full earmolds.

When I first started dating my wife Kelly, I was worried that my hearing loss would bother her and that she'd be frustrated when carrying on conversations with me. She had assured me that this is not and was never the case. My wife had little to no experience with a person with a hearing impairment and has learned a great deal on how to accommodate me. It takes a lot of patience on both our parts, but we are happily married and she fully accepts me just the way I am.

I was interested in hearing aids for most of my childhood and would always look forward to going to my appointments to get my hearing aids cleaned, and repaired, or to get new tubing put in my earmold. These experiences inspired me to become a hearing instrument specialist. I have always loved helping people so why not help people with hearing loss? I attended George Brown College's three year Hearing Instrument Specialist program in Toronto. It was a very rewarding experience and I graduated in April of 2007.



Talia, Scott, and Kelly.

I now work for ListenUp! hearing care centre in Napanee. I truly enjoy what I do and I work very hard with each patient I see. It gives me immense satisfaction to help others with hearing loss. I can relate to them and they can relate to me.

I also enjoy teaching people about hearing aids and my own experience with hearing loss. It gives them a greater understanding of hearing loss and what someone with the condition goes through. I remember four years ago I was a guest speaker at the Annual Senior Citizens of Ontario conference in Oshawa. It was a wonderful experience for me and I had the chance to speak to many people on topics relating to hearing loss and hearing aids. My presentation was meant to only be 15 minutes including a question period, but it ended up being an hour long. Everyone loved my presentation and had many questions. I had people come up to me and tell me how much of an inspiration I was to them. It was a great feeling.

I'm a very active person and my hearing loss has never stopped me from pursuing an activity or a goal. I took up scuba diving four years ago and when I am underwater, I feel free since everyone communicates virtually without sound and I don't feel like I am missing anything! The only other times I feel peaceful are when I am alone or sleeping.

My wife Kelly and I welcomed Talia, a beautiful baby girl into our world on May 13, 2011. She is very special to us and a truly amazing little girl and brings so much more happiness into our lives. Talia also brings more challenges for me, trying to hear her and understand what she is saying can be difficult at times but it is getting better as she gets older. I know that she will eventually learn to talk to me in a special way because she knows her Daddy has a hearing loss.

I was elected into the Association of Hearing Instrument Practitioners of Ontario (AHIP) as a director in May 2012. This new position has been exciting, challenging and a great learning experience for me and I feel very proud to represent the members of AHIP. I also joined the Rotary Club of Napanee which is exciting and I do a lot of volunteering and fundraising in the community for the club and recently announced a new splash pad for the community which we are very proud of.

My hearing loss has made me who I am. I am compassionate, tolerant, and most of all content. I can easily say that because of my hearing loss I have never had a day off, but I would not wish to have it any other way.

I would like to thank my wife Kelly for helping me write this article. I would not have been able to do it without her help.

For any questions or more information, please contact me by e-mail at scl@listenupcanada.com or by phone at (613) 354-7000. Alternatively you can visit the ListenUP! Canada website at www.ListenUPcanada.com or come see me in Napanee at 307A Bridge Street.

The $50,000 Fruit Basket

By John Niekraszewicz

When dealing with elderly clients, one duty that we have is to be aware of potential elder abuse. This may take various forms including physical, mental, and financial abuses. My personal experience is that financially, many elderly couples are extremely well off thanks to generous government and employer pension plans that are indexed to inflation. It is not unusual to meet couples in their 80s who have a combined income that is now even higher than it was in their most productive working years. They also have a large portion of their medical expenses paid for by either the government or company benefit plans. So why is it that they are reluctant to purchase the very best and latest medical care and devices that money can buy?

Partly it is because of the time period they grew up in. The formative years between the ages of 5 to 15 are significant in establishing individual beliefs and expectations. People born between 1920 and 1929 would be 83 to 92 years old in 2012. The major events that influenced their lives would be the 1929 stock market crash, the Great Depression of the 1930s and World War II.

Living through this period of time has taught them to be frugal, live within their means, not go deep in debt, and save for a rainy day. And today many of these people have the same concerns when it comes to money and health, which include the following:

- Being able to afford to live in their home for their entire lives
- Being able to preserve their wealth so a financial legacy can be left to loved ones
- Not being a burden to family members

When it comes to discussing financial matters or arranging for outside caregiving, many family members don't want to get involved or interfere. Especially if the elderly couple, even though they might be processing information slower, are still able to make intelligent decisions. But, what may appear to be intelligent decisions may prove to be otherwise. This is where outside caregivers can have a strong influence over financial decisions, leading the elderly to believe that they cannot afford the best medical care and devices that they deserve. So, what are some of the red flags that point towards undue influence and potential financial abuse?

Bob and Mary's situation is a classic example. Their grown children had families of their own, professional careers, and lived in different cities. Bob and Mary were still capable of handling their financial affairs but had started to experience health and mobility issues. Not wanting to burden their adult children, they arranged for an outside caregiver to assist with household chores, drive them to appointments, and eventually shopping and banking. The caregiver was seen as an extended member of the family and was providing very good care. All of the family members seemed happy but after a year, some red flags appeared.

On one visit, Bob and Mary's daughter noticed that the caregiver had changed some furniture and added her decorative touch to the house. Not wanting to interfere with what seemed like a good arrangement, only a few minor suggestions were made to the caregiver that would provide more comfort for her parents. One suggestion was to lower the fruit basket. But when this simple request was dismissed, suspicions arose.

Upon a financial review, it was discovered that the caregiver had mismanaged expenses to the tune of $50,000. No wonder Bob and Mary felt they had no money. Luckily, this injustice was caught quickly. Bob and Mary's financial affairs were straightened out and they received the medical products and services they rightfully deserved.

Unfortunately, the enormous wealth of baby boomers, dysfunctional family dynamics, and tough economic times will only cause financial elder abuse to become a growing problem and concern.

As professionals running a client-centric practice, we are in a position to identify potential financial abuse by understanding our client's family dynamics better and being aware of the red flags. When it comes to giving your elderly clients a choice between different products, one idea is to suggest a family meeting where they can discuss the product features and financial options. This one suggestion may lead to a caregiving financial planning review which is what your clients may have always wanted, but didn't know how to bring up the topic to family members.

John Niekraszewicz (Nick-ra-shev-itch) BMath, FCSI, CFP, FMA is the Certified Financial Planner responsible for the AHIP Health & Dental Benefits Plan provided by JVK Life & Wealth Insurance Group. John is also the Principal of JVK Life & Wealth Advisory Group, a firm providing investment, retirement, tax & estate planning. John welcomes your questions and can be reached at john.niekraszewicz@jvkgroup.com or 1-800-767-5933.

Elder Abuse: A Growing Dilemma in An Aging Population

Canada is becoming an older country. According to Statistics Canada, 25% of the population will be over the age of 65 by 2031. That's about 8 million people. Unfortunately, a growing number of those in this age bracket are reporting that they are the victims of abuse.

Signs of Elder Abuse

Elder abuse can manifest itself in a number of behaviours that are noticeable to those who most frequently interact with the elderly such as family, friends, neighbours, physicians, retailers, bankers, social workers, and police.

Some Indications of Abuse

A sudden change in behaviour or appearance
A sudden onset of physical injuries
A change in financial resources
The strongest indicator that an elderly person is being abused is that he or she will tell someone

Forms of Elder Abuse

Neglect (self or by others)
Physical Abuse
Sexual Abuse and Exploitation
Psychological and/or Emotional Abuse
Economic / Financial Abuse
Institutional Abuse
Violation of Rights
Spiritual Abuse

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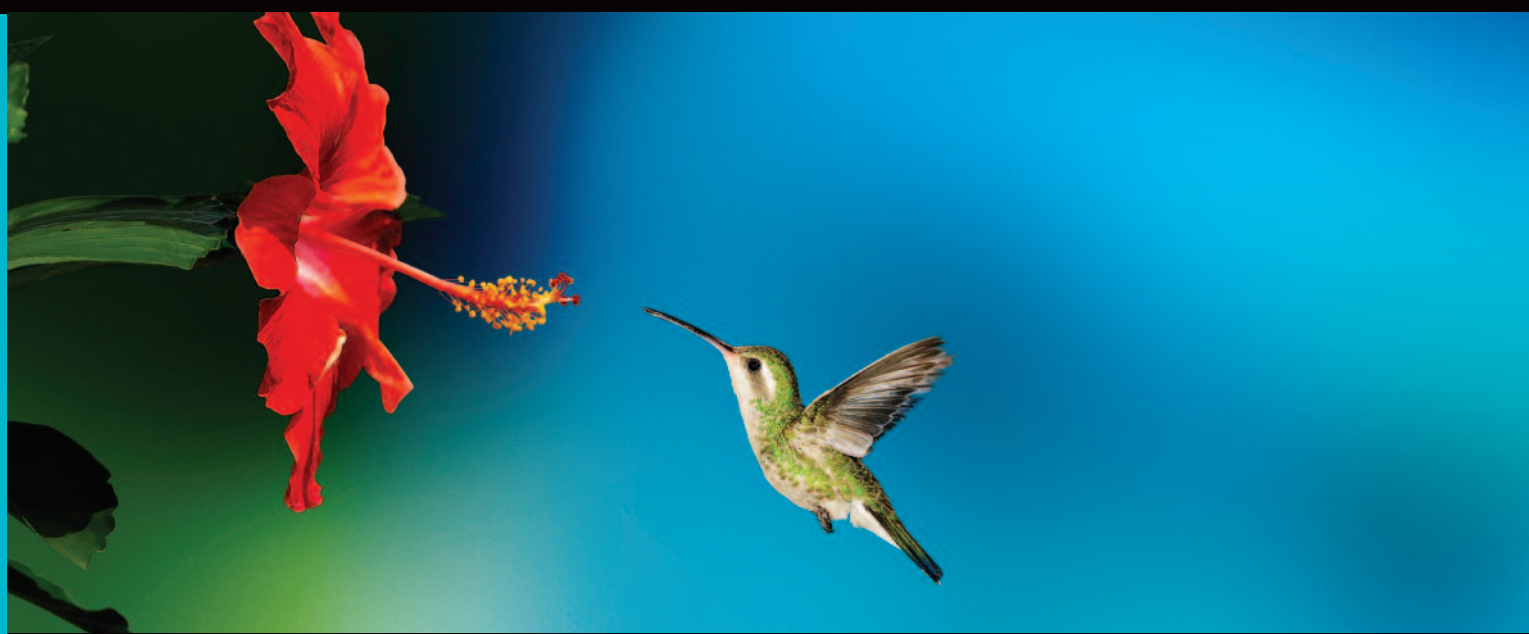

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