Motivational Interviewing:
When patients request hearing aids
but don't want them!

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Presbycusis, Mortality and Brussels Sprouts:
The story of Norma

What did hearing aids symbolize for her???

Sometimes it's just a cigar, but sometimes it isn't...
Story of Joan:
“I asked for hearing aids but didn’t want them.”

Son: Mark
Daughter: Janice
Son-in-law: Tom

A possible initial interview of Joan

A: “How can I help?”
J: “I came for hrng test and HA.”
A: “Would you tell me who referred you or knows that you came for a hearing test?”
J: “My son.”
A: “Tell me about your son.”
J: “Well, he’s Mr. Know-it-all, and has been badgering me to get hearing aids for years.”

A: “I see (smiles). Who else is concerned about a possible hearing loss?”
J: “My daughter Janice and her husband, Tom.”
A: “And which of them – Mark, Janice, or Tom – would be most concerned if you did or did not get hearing aids?”
J: “Definitely Mark. Janice and Tom are more compassionate. They would understand that it’s my decision.”
A: “I see. And what would they do?”
J: “Mark would get angry and scold me. Janice would come to my defense, and they would fight. Then eventually Tom would break it up.”
A: “Whew. And how would all that affect you?”

J: “I want no part of it. I want out of this family. Mark can take his hearing aids and… And frankly, since my husband died, life’s not worth living anymore.”

A: “It feels very bleak to you, I bet. Lot of emotions and people involved.”

J: Nods her head.

A: “So we may not want to go full force toward fitting you with hearing aids. But would it be okay if we maybe talk for a bit about your concerns and go ahead and test your hearing, but hold off on treatment until I understand more how it would fit into your life and family issues?”


Circular questioning:
How to find out who those invisible people are:
The Relevant System.

“Who referred you for this meeting?”

“Who knows about this meeting?”

“Who will notice improvement in your hearing first, second, third, etc.?” “Who will not notice at all?”
Circular questioning?

“Who will be most pleased if your hearing improves? Who will be the second most pleased? Etc. Who will be the most upset if your hearing doesn’t improve? And then who? Etc.

“What do you think will happen between [any two people] if your hearing improves? If your hearing doesn’t improve?

“Whom do you think the outside help has helped the most? And then who? Etc.

Is this familiar?

Practitioner advocates for change

Patient advocates for staying the same

“You should change”

“I don’t wanna change.”

“You’re better off with HA”

“Things aren’t half-bad.”

“You’re ready to…

“No, I’m not ready to.”

“You’ll have poorer quality of life”

“Uncle Fred is 89 and he’s doing fine.”

Motivational Interviewing

A directive, patient-centered counseling style for increasing intrinsic motivation by helping patients explore and resolve ambivalence.

(Miller & Rollnick, 2002)
Question from father: “What did the doctor say about what’s wrong with our son?”
Mother’s response: “He was a very nice man. . . . .”

A 70-year old woman said that she finally got hearing aids after many appointments with many dispensers. I asked her “Why now?” She replied, “He was the first person to ask me how I’m doing and who wanted to hear my answer.”
“They may not remember what you said. They may not remember what you did. But they’ll never forget the way you made them feel.”

Mother Theresa

Relational Stance
Way in which we approach clients; how we position ourselves in relation to clients. Not “who” we are with clients, but “how” we are with clients.

- Relational stance of expert/information provider. This is the focus of most medical/allied medical training.
- Relational stance of Appreciative Ally:
  Respectful curiosity or collaborative inquiry: Standing in solidarity with clients. Honoring of the privilege of being invited into and having an opportunity to share in the client’s lives.

Stages of Change

1. Pre-contemplation: Pt denies HL.
2. Contemplation: Pt is ambivalent about change.
3. Determination: Pt requests change. (Diagnostic and prescriptive tasks work well here).
4. Action: Pt accepts HA or remediation.
5. Maintenance: Pt practices strategies to maintain change.
6. Relapse: Pt practices strategies to prevent relapse
1. **Pre-contemplation Stage**

Pt denies the HL.

**Provider tasks:**
- Elicit pt’s story, be curious, and LISTEN;
- Rapport building

*In this stage, prescriptive advice often leads to resistance.*

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“**How Doctors Think**”

By Jerome Groopman

Question: “On the average a physician will interrupt their patient describing his/her symptoms within ?? period of time?”

18 seconds

1st umpire: “I call them as they are.”
2nd umpire: “I call them as I see them.”
3rd umpire: “They are as I see them.”
Goal: to elicit & validate affect re HL
Open-ended questions, reflective listing & affirmation

**Bounded, MI Open-Ended Questions:**
Ask about emotional experiences of HL, while referencing time limits; i.e., “We only have a few minutes, but can you give me a snapshot of how you’re feeling?”

Try to avoid asking three questions in a row. If unavoidable,
- Intersperse reflective listing & feedback between questions
- Ask permission first.
- Use humor and apologize for acting like an interrogating, cross-examining attorney

**Reflective Listening**

**Simple Reflection:** reflects exactly what is heard
- P: “I don’t want HA.”
- Δ: “It’s something you don’t wanna do, right?”

**Double-Sided Reflection:** reflection presents both sides of what the pt is saying, extremely useful with pointing out ambivalence
- P: “There is no question that I wanna understand my grandchildren. However, after a while all the fighting and noise gets to me.”
- Δ: “So, on the one hand you’re very clear that your grandchildren are very important to you. However, you also appear to be saying that sometimes you just want peace and quiet.”

**Amplified Reflection:** amplifies or heightens the resistance that is heard
- P: “I couldn’t wear HA. What would my friends think?”
- Δ: “It sounds like what your friends think is of the utmost importance.”
  (“MUST-erbating.”)

**Affirmation: Recognize, Support, & Validate pt’s feelings**

- “Many people with HL feel…”
- “It’s normal to feel…”
- “It sounds like you’re still struggling with making these changes, but you’ve made some changes. It’s not as easy at it looks, huh?”

Avoid saying: “I understand how you feel.”
Self-perception theory: What people say about change predicts behavior change; one's attitude is shaped by the act of talking.

Therefore the practitioner should get the patient to do most of the talking: to verbalize rationale for change.

Goal: To elicit Self-Motivational Statements from patient

Problem recognition: e.g., "I guess there’s more of a HL than I thought."

Expression of concern: e.g., "I’m really worried about…"

Intention to change: e.g., “I think it’s time for me to…”

Degree of self-efficacy to change: e.g., “I think I can do it.”

Eliciting HL recognition

• “Why do you believe you have a hearing loss?”
• “In what ways do you think you or other people have been affected by your hearing loss?”
• “Tell me about how much hearing loss you have, when it started.”
Eliciting concern

- “What worries you about your hearing loss? What can you imagine happening to you?”
- “How do you feel about your hearing loss?”
- “How much does your hearing loss concern you?”
- “How has your hearing loss stopped you from doing what you want to do?”
- “What difficulties have you had in relation to your hearing loss?”

Eliciting intention to change

- “What makes you think that you may need to get hearing aids?”
- “If you were 100% successful and hearing aids worked out exactly as you would like, what would be different?”
- “What have you learned about how hearing aids may help?”
- “How has your hearing loss stopped you from moving forward, from doing what’s most important in your life?”

Eliciting self-efficacy to change

- “What encourages you that you can get hearing aids if you want to?”
- “What might stand in your way of getting hearing aids?”
- “What are the options for you now? What could you do?”
- “How do you imagine you getting hearing aids?”
Eliciting importance

1. How important is it for you right now to change?

0 .......................................................... 10
Not at all important                                             Extremely important

A. Why are you at [x?] and not at 0?
B. What would need to happen for you to raise your score a couple of points?

Eliciting confidence

2. If you did decide to change, how confident are you that you could do it?

0 .......................................................... 10
not at all confident                                             extremely confident

A. Why are you at [x?] and not at 0?
B. What would need to happen for you to raise your score a couple of points?
C. How can I help you get there?

Stages of Change

2. Contemplation Stage
Pt is ambivalent - considers change but rejects it.
Provider tasks:
• frame ambivalence as normal & acceptable;
• deliberately and respectfully amplify (pun intended) both sides of the ambivalence.
• develop discrepancy. Help pts differentiate between where they are and what they want.
Prescriptive advice continues to be counterproductive.
Managing Pt Ambivalence

What you don’t talk about can hurt you.

Decisional balance sheet

<table>
<thead>
<tr>
<th>No hearing aids</th>
<th>Get hearing aids</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>1. Save money.</td>
<td>1. Overhearing information.</td>
</tr>
<tr>
<td>2. Avoid stigma.</td>
<td>2. Feeling included.</td>
</tr>
<tr>
<td>3. Save time with appts.</td>
<td>3. Understanding lectures.</td>
</tr>
<tr>
<td>4. Avoid adjustment period.</td>
<td>4. Order of things is still...</td>
</tr>
<tr>
<td>5. Everyone needs to speak.</td>
<td>5. Less isolated.</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
</tr>
<tr>
<td>1. Miss conversations.</td>
<td>1. Cash outlay.</td>
</tr>
<tr>
<td>3. Depression.</td>
<td>3. Looking old.</td>
</tr>
<tr>
<td>4. Cash that can't be used.</td>
<td>4. People pitying me.</td>
</tr>
<tr>
<td>5. Not as productive.</td>
<td>5. Don't like being dependent.</td>
</tr>
</tbody>
</table>

Joan's decisional balance sheet

<table>
<thead>
<tr>
<th>No hearing aids</th>
<th>Use hearing aids</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>1. Will be with Alex again [deceased husband].</td>
<td>1. More involvement with family.</td>
</tr>
<tr>
<td>2. Finally get last word with Mark.</td>
<td>2. More enjoyable listening.</td>
</tr>
<tr>
<td>3. Avoid signs of looking old.</td>
<td>3. Less fatigue and anxiety hearing.</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
</tr>
<tr>
<td>1. Miss out with grandchildren.</td>
<td>1. Mark might say: “I told you so”.</td>
</tr>
<tr>
<td>2. Not hearing movies.</td>
<td>2. Mark and Janice would fight.</td>
</tr>
<tr>
<td>3. Will miss out with TV &amp; more.</td>
<td>3. Mark and Janice would fight.</td>
</tr>
<tr>
<td>4. Avoid stigma of looking old.</td>
<td>4. Less isolated.</td>
</tr>
</tbody>
</table>
3. Determination Stage

Pt’s motivational balance tips toward change and represents a short window of opportunity for direct intervention. Diagnostic and prescriptive tasks work well here.

Provider task:
• help the patient determine and plan the best course of action to take in seeking change.
• Luterman and Clark & English strategies are particularly applicable here (as with other stages)

David Luterman: 3 types of pt questions

- **Content**: Pt seeks information. eg., “What’s my HL?”
- **Confirmation**: Pt asks a question in the hope that the audiologist will confirm an opinion or position that the pt has already formed. eg., “Do you think the school that we have chosen is a good choice for our daughter?”
- **Affective-based**: Pt asks a question that is rooted in an underlying emotional need. eg., “Could stress have caused my son’s HL?”

The Content Trap

Assuming every question is a content question. Failing to listen beyond content; to recognize and respond to the underlying motive to a pt’s question.

John Clark & Kristina English

“If the only tool you have is a hammer, you’ll see every problem as a nail.”
Guidelines for audiologist’s responses
John Clark & Kristina English

**To content questions:** Answer the question!

**To confirmation questions:** eg., “Do you think we should sign with our child?”
   Resist temptation to immediately answer or lecture, as these questions are often “loaded.” Ask pt his/her opinion first and then “fold in” your opinion.
   eg., “What have you heard about signing? What do you see as pros and cons? . . . “Well, yeah, signing would be helpful to . . .”

**To emotional ques:** eg., asks, “Do you think that HA makes a person feel old?”
   Respond to the underlying “subtext” of the question. Often it may not be necessary (or helpful) to answer the question.
   eg., “You may be self-conscious of HA and think that it makes you look old, is that right?” “We have a few minutes. Pls tell me a bit more about how that feels.”

John Doe returns for a post-HA fitting check and asks why he continues to miss some communication. The audiologist perceives that he has unrealistic expectations of HA.

Content response: Inform pt on limitations of HA
Confirmation response: “I have some thoughts, but I’m curious for your opinion about why you continue to miss some things.”
Emotional response: “I sense how frustrating this may be for you. Would you tell me about how you feel and about times you do and don’t miss things?”
4. Action Stage

This stage is what people often think of hearing aid dispensing or audiologic remediation.

Provider task:
• help the patient take actual steps toward change, such as a hearing aid fitting.

5. Maintenance Stage

Provider task:
• Help pt sustain the change
• Help pt identify and use strategies to prevent future relapse.

Highlight and affirm pt’s positive changes: Point out any changes you have observed with the pt and ask them how they did this.
A: “It sounds like you have made real progress. How did you do this? How do you feel about your progress?”
A: “It sounds like you are still struggling with making these changes, but you have made some changes. How do you think you might continue making progress?”

Summary Statements: Pull together the comments made; transition to next topic
A: “You mentioned a number of things about your current lifestyle, such as work, that make effective communication important. Maybe we can talk about what environmental accommodations would be helpful.”
Reframing: Places a different meaning on what the pt says in order to decrease resistance. (Always validate feeling before reframing)

Pt: HA is for old people who are getting ready to die.

Δ: Many older people feel that way, and it’s true: they need and benefit by HA, but in order to live better -- not to die.

Developing Discrepancy: Create a gap between where the person has been or currently is and where they want to be; goal is to resolve discrepancy by changing behavior

Δ: What will your life be like (# years from now) if you do and don’t make accommodations to your HL?
Δ: If you keep going the way you are going where will you be five years from now?

Colombo Technique: Used when clients are presenting conflicting information or behaviors

Δ: “On the one hand you say you are feeling isolated and frustrated about not understanding conversations, but you continue to forget to use your hearing aids which you said have helped. I'm confused. Help me understand this.”

6. Relapse Stage

Relapse is conceptualized as a common occurrence. Can predict it to pt

Provider task:

• Prevent demoralization. Distinguish relapse from lapse.

ie.: Failure to use one’s hearing aids – relapse – need not precipitate returning the aid or storing it in the dresser drawer.
Common Provider Traps

- The Confrontation-Denial Trap
- The expert trap
- The labeling trap
- The Premature-Focus Trap
- The Blaming Trap

Common Patient Avoidance Behaviors

1. **Arguing**. The patient contests the accuracy, expertise, or integrity of the provider.
   
   - **Discounting**. The patient questions the provider's personal authority and expertise.
   - **Hostility**. The patient expresses direct hostility toward the provider.
   - **Challenging**. The patient directly challenges the accuracy of what the provider has said.

2. **Interrupting**. The patient breaks in and interrupts the provider in a defensive manner.
   
   - **Talking over**. The patient speaks while the provider is still talking, without waiting for an appropriate pause or silence.
   - **Cutting off**. The patient breaks in with words obviously intended to cut the provider off (e.g., “Now wait a minute. I’ve heard about enough.”)
3. **Blaming.** The patient blames other people for HLs.

4. **Disagreeing.** The patient disagrees with a suggestion that the provider has made, offering no constructive alternative. This includes the familiar “Yes, but...”

5. **Excusing.** The patient makes excuses for his or her own behavior.

6. **Minimizing.** The patient suggests that the provider is exaggerating the handicap, and that it “really isn’t so bad.”

7. **Pessimism.** The patient makes general statements about self or others that are pessimistic, defeatist, or negativistic in tone.

8. **Unwillingness to change.** The patient expresses a lack of desire to change, or an intention not to change.

9. **Inattention.** The patient’s response indicates that he or she has not been following or attending to the provider.

10. **Non-answer.** In answering a provider’s query, the patient gives a response that is not an answer to the question.

11. **No response.** The patient gives no audible or nonverbal reply to a provider’s query.

12. **Sidetracking.** The patient changes the direction of the conversation that the provider has been pursuing.

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**Motivational Interviewing Principles**

- Providers should use different approaches with patients, depending on their stage of change. Don’t be in such a hurry to fix the HL.
- Avoid giving premature advice.
- Respect the centrality of ambivalence: “I want to but don’t want to.” No decision is made with 100% certainty.
- Providers are responsible to help motivate the pt — not only to dispense advice.
- Talk less. Be curious more.
Isn’t this like selling?

Yes, it is

“Questions persuade more powerfully than any other form of verbal behavior.”

“The most effective salespeople were the ones who did an outstanding job of building needs during the investigating phase.”

“I’ve never been a believer in closing… because my objective is not to close the sale but to open a relationship.”

Neil Rackham. Author of Spin Selling

Advantages of Motivational Interviewing

- Increases patient’s motivation (hence the name)
- Patient-professional relationship becomes collaborative, not adversarial.
- We learn more and burnout less.

“We have the experience of knowing intimately people we would otherwise not have known, and of sharing vicariously in others’ life choices and struggles, their most intimate feelings, needs, and concerns which get sparked by their loss of hearing.

Our connections with clients contribute to our growth as individuals, add complexity to our lives, and increase our capacity for empathy and understanding. They teach us the things we might have learned from wise elders. Sharing joy and sorrow, laughter and pain, wisdom and ideas with another person is at the heart of what it means to be human.”

From a seasoned audiologist
My hope for you after this seminar:

“Transformative interviewing”

“I hadn’t realized that she was coming to see me for more than her ears.”

Audiologist, PCO doctoral student

The Transformative Power of an audiologist visit:

- Focus on third point
- Sessions bounded by space & time
- Imprinting during crisis
- Bearing witness to pt's story
Bermuda, Here I Come!
Letter from a mother for the annual convention of (then called) Assoc Dispensing Audiologists, Oct 27, 1999

Dear audiologists,

“Thank you for touching peoples’ lives through some very difficult moments. You give me a sacred gift for which I don’t have enough words to properly say thank you.

Let me try anyway... Thank you for your technical expertise: your ability to explain what all those knobs do and what they mean. But most of all, thank you for being there, for listening, for your comfort and for your patience - for making it possible for me to leave your office with confidence and hope.

“Tommy is now 15 years old and he’s a happy kid and doing well in school. His hearing loss has become a normal part of our lives largely because of you. I bet your clients ‘double click’ you to meetings in their heads like I still do without you even knowing it, and that your spiritual presence in their lives helps make everything okay.

With much gratitude and love, Joan.”

Integrating Counseling Skills into Existing Audiology Practices
Kristina English, Ph.D.

- 53 respondents to questionnaire to Au.D. students with average of 14.6 years of experience
- Approximately 50% expressed deep concern about the feasibility of “adding” counseling strategies into already tight schedules.
- 50% also reported that they found ways to “fold” counseling strategies into their practices in ways that did not require additional time.
- “I am finding that careful listening/counseling in the beginning is resulting in fewer return visits, so in this way I actually come out ahead, time-wise.”
- “Instead of spending 10 minutes talking about test results and management strategies, I try to ask the patient what they thought about the testing, and let the patient guide the direction of the conversation.”

Make psychotherapy referral, prn

“You can only wear so many hats and we shouldn’t beat ourselves up if we can’t solve all of a given patient’s HLs. Part of being a good audiologist is recognizing when a patient is having a tough time dealing with hearing loss and making an appropriate referral to a psychotherapist who is trained to deal with these issues.”

Audologist, PCO doctoral student
How to refer successfully to mental health professionals

Common responses of audiologists to patients who exhibit psychological distress:

• “Emotional issues are beyond my area of expertise, so I would like to refer you to a psychotherapist.”
• “I’m sorry, we can’t get into emotional stuff here as our appointment is only 10 minutes. A therapist can help you.”
• “Do you think you need psychotherapy?”
• “Given the pain that you feel, you can benefit from therapy.”
• “You have to think positive about the hearing you still do have!”

The good news: These approaches seem effective and make intuitive sense.

The bad news: They’re likely decrease the probability of a successful mental health referral and possibly disrupt the audiologist-patient alliance.

The respective patient would likely feel

➢ Stigmatized, defensive and/or rejected. e.g., “Dr. Smith doesn’t care about how I feel and just wants to get rid of me.” Or “Dr. Jones thinks I’m crazy!”
➢ The positive-thinking suggestion may cause some patients to feel emotionally invalidated – like putting a bandage on a gushing wound.

1. Validate and contain the patient’s feelings

For example:

• “Many people also say that they feel anxious about their hearing loss. We only have 5 or 10 minutes, but would you give me a snapshot of how you’re feeling anxious?”
• “It sounds like you have a lot of painful feelings. I can appreciate that, as I’ve heard many many people with hearing loss talk about this a lot. We don’t have more than a few minutes, but I’d really appreciate it if you could give me a glimpse of your pain.”
• “I cannot completely understand your pain since I’m not
you, so I won’t insult you by saying ‘I understand.’ But
of course you feel depressed, scared, anxious having just
lost your hearing! Frankly, if you didn’t have those
feelings, I’d be concerned, as your feelings are quite
normal. Later, we can talk about all that more, but can
we finish doing…?”

2. Normalize (de-stigmatize) the referral

For example:

• “Many people with hearing loss feel it’s helpful to really talk about the
emotional stuff that you just talked about. I know someone …”

• “I have found that people benefit more from hearing amplification if
they talk about the emotional adjustment issues.”

• “There is a set of psychological skills that people with hearing loss
learn to use. Would you be interesting in meeting with . . .?”

• You know, there are audiological ways of helping with hearing loss
and there are also psychological techniques. The first is something I
do; the second is another professional I know.”

3. Emphasize that optimal treatment of hearing loss necessitates a **team** approach

For example:

• “I’m happy and proud to tell you that we have a kind of
dream team’ to help people…”

• “I’ve found it more successful to use a holistic, team
approach to help people benefit from hearing aids.”

• “I can take care of your ears, and another person can take of
your emotions; we’ll cover all bases.”
4. Humanize the mental health professional

For example:

- “I’ve known Dr. Smith for over 20 years. She’s nice, maybe about 50 years old, been practicing psychology for over 30 years. I think she also collects antiques. She has a dry sense of humor. I think you’ll like her.”

5. Ask permission to telephone the mental health professional in front of the patient

For example:

- “Is it okay if I call Dr. Jones now to give her a heads up that you’ll be calling?”

6. Ask the patient about the status of the referral appointment

If a patient did not follow through on contacting the therapist, an audiologist may ask:

- “Hey, this is not the kind of thing that points are taken off of your final grade. But would you help me understand what you were thinking or feeling that may have made you not make the call?”
- “You know, this is easy for me to suggest. I have the easy part. Tell me how it feels for you?”
- “Is there any information or assurances about Dr. Shilomo that I can give you that would be helpful?”
Bed-time reading:
Stories from my psychotherapy practice

“There’s a grammatical error on page 12!!”
Mike’s mother

Handouts

- Audiology and Motivational Interviewing: A Psychologist’s Perspective
- How to refer successfully to mental health professionals
- I never wanted to be a salesman but here I am
- The Transformative Power of an Audiology Visit

Questions, Answers, and Discussion