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Motivational Interviewing and Amplification

by Douglas L. Beck, AuD; Michael A. Harvey, PhD; and Donald J. Schum, PhD

In general, dispensing professionals see patients who have *elected* to come through the door—for whatever reason. If managed and counseled effectively using Motivational Interviewing, these patients have an excellent chance of seeking amplification, as they are often on the verge of change and are already pursuing positive personal choices.

As hearing care professionals, we endeavor to relate to, inspire, and motivate people with hearing loss to address their hearing problems through knowledge, noise protection, aural rehabilitation, and amplification. Unfortunately, although hearing care professionals and the health care community have tried numerous approaches (see the sidebar "Some Philosophical Approaches to Patients/Clients"), people with hearing impairment remain reluctant and resistant to use hearing aids.

People with hearing loss are rarely inspired or motivated to seek hearing assistance via amplification. Multiple sources report only 1 in 5 people who could benefit from amplification obtain hearing aids.[1] We believe that more successful interventions could be achieved by incorporating Motivational Interviewing into the process.

General Concepts of Motivational Interviewing

Motivational Interviewing (MI) is a focused, goal-directed, patient-centered approach and counseling tool. MI works by eliciting patient-based behavioral changes through the articulation and tolerance of ambivalence. It may be worthwhile to review the definition of ambivalence:

am·biv·a·lence: uncertainty or fluctuation, esp. when caused by inability to make a choice or by a simultaneous desire to say or do two opposite or conflicting things. The coexistence within an individual of positive and negative feelings toward the same person, object, or action, simultaneously drawing him or her in opposite directions.[2]

MI has been successfully employed as a counseling tool and discourse approach with regard to drug addiction, alcohol rehabilitation programs, gambling, and tobacco cessation programs.[3]

Core concepts of MI include:

- Collaborative participation of the patient in the process.
- Motivation to change comes from the interaction between the patient and the counselor.
- The counselor elicits the patient's thoughts and needs through directed discourse.[4]
- The counselor's task is to help the patient articulate ambivalence issues while guiding the patient to the "better alternative," such as a positive change.
- The goal of MI is for the patient to willfully and willingly seek change.

Despite the specific professional-to-patient philosophical approach chosen—including the Medical Model, Audiogram Review, Social, and others (see sidebar)— the most important element for success is the collaborative participation of the patient in the discussion and the process. However, as a profession, we have often approached the patient armed with audiograms, data and spec sheets, warranty and pricing guidelines, and other documents that "prove our point" while alienating the patient. When we approach the patient in our traditional manner, the patient becomes the "recipient" of the information, rather than an engaged partner in the discussion.

With MI, the counselor is encouraged to roll with resistance, enhance the intrinsic motivation to change, and help patients articulate and discuss their reasons to change behaviors, all in a nonconfrontational

atmosphere. When the patient actively participates in the process and perceives a need and desire to change, the process has a greater likelihood of succeeding. When the patient internalizes a need to change, the emphasis moves away from specific technology (ie, advanced hearing aid technology) and focuses more on the patient and the outcome.[5]

Motivational interviewing techniques help people make positive decisions and behavioral changes based on their perceived needs, desires, options, and alternatives. Importantly, within the framework of MI, the clinician must be highly skilled and goal-oriented to facilitate the patient's articulation of their goals and resolution of ambivalence, with due respect for the importance of achieving the goals with confidence—and that the goals can be achieved.

Douglas L. Beck, AuD, is director of professional relations at Oticon Inc, Somerset, NJ; **Michael A. Harvey, PhD**, is a clinical psychologist in private practice in Framingham, Mass, and adjunct faculty at Boston University and consultant faculty at Pennsylvania College of Optometry, School of Audiology; and **Donald J. Schum, PhD**, is vice president of audiology and professional relations at Oticon Inc.

Motivational interviewing is a psychological protocol that can be used to increase patient adherence to audiologic recommendations.

Objectives in MI. The goal of MI is for the patient to reach the decision to change. To facilitate achievement of the goal, the hearing care professional weaves into the interview strategic open-ended questions and discourse to elicit four categories of self-motivational statements from patients:

1. Problem Recognition
2. Expression of Concern
3. Intention to Change
4. Self-Efficacy to Change

In psychology, it is well known that most people are ambivalent about most decisions. Rollnick and Miller[4] cite many examples, such as: the agoraphobic person who truly wants to go outside and experience the world, but is terrified to do so; socially isolated people who want to window shop and enjoy the activity and excitement at shopping malls, but feel they are not worthy or attractive enough to be seen in those environs; the compulsive hand-washer who wants to avoid their ritual, yet is driven to it over and over. These "approach-avoidance" conflicts are characteristic of many addictions and addictive behaviors. The person wants to change, and the person doesn't want to change. The result: ambivalence.

Accordingly, when engaging an MI approach, the dispensing professional should assume the patient is ambivalent about using hearing aids, show respect for that ambivalence, and collaboratively elucidate both sides of the ambivalence—*the pros and cons of acquiring hearing aids, as well as the pros and cons of not acquiring hearing aids*.

Illustrative Case Study

Of course, no single case study can adequately present all aspects of MI. Nonetheless, in this idealized question-and-answer exchange, we'll illustrate some of the concepts and strategies associated with MI.

Mrs Smith noticed increasing difficulty understanding specific words, particularly in noisy environments. She reported difficulty understanding words for 5 to 7 years.

To elicit statements regarding problem recognition, and as a standard part of her intake exam, the dispensing professional asked Mrs Smith specific MI-based questions. The professional was careful to write each answer, in plain sight, as soon as Mrs Smith responded. In this way, Mrs Smith knew every answer was being carefully noted.

Q Why do you believe you may have a hearing loss?

A *Well, I'm not really sure I do have hearing loss.*

Q OK. Is there something that sometimes makes you think you might have hearing loss?

A *Well, sometimes I don't understand all the words and sometimes I have to ask people to repeat things. People don't speak clearly anymore, and they don't pronounce all the sounds.*

Q I understand. It's hard to tell what some people say. Do you do about the same everywhere, or is it harder to hear in particular places?

A *That's a good question. I can't understand very well in noisy places, like a store, the mall, or a restaurant.*

The audiologist continued to gather a complete audiometric history and a comprehensive audiometric evaluation. The audiometric evaluation revealed moderate, bilateral sensorineural hearing loss. Mrs Smith's word recognition score in quiet at a comfortable loudness level was determined to be 80% in each ear. The audiologist recommended binaural hearing aids.

Mrs Smith replied she wasn't sure her hearing problem was bad enough for hearing aids, and she admitted her concerns that hearing aids might make her look older and less competent. She also mentioned there were so many other health issues in her life that hearing just wasn't that big a deal to her.

Understanding how ambivalence tends to degrade these situations, the dispensing professional used additional Motivational Interviewing techniques to help address and manage her ambivalence.

To further evaluate and elicit expressions of concern, the professional asked:

Q What worries you about a possible hearing loss?

A *I'm not really worried about my hearing. I'd just like to hear better! But it really bothers me when people don't speak clearly.*

Q I understand that can certainly be a problem. How do you feel about your own hearing loss?

A *Well, as I said, I'm OK with it. I just have to avoid certain noisy and difficult situations, and try to not put myself in situations where I can't hear very well.*

Q How much does that concern you?

A *Not very much, at least most of the time. Although sometimes it's a real problem.*

Q In what ways do you think you or other people have been affected by your hearing?

A *Sometimes I ask people to repeat what they just said. It's a little embarrassing. Sometimes I stay home instead of going out with my friends, because some places are too hard for me to hear.*

Q Has your hearing stopped you from doing what you want to do?

A *Well, not really. Sometimes I hesitate to go shopping, or if we're playing bridge, I have to make sure the stereo and the television are turned off, or I can't hear the card game at all.*

Q What do you think will happen if you don't get hearing aids?

A *I guess I'll just continue on as before, missing a few things now and then, but doing OK. If only people took a little more pride in their voices and pronunciation, it would be a lot easier!*

Q Do you remember a time when your hearing was better than it is now?

A *Yes, of course. Maybe that's why this is so frustrating for me. I do recall when I could hear a pin drop, and so not hearing very well now reminds me I'm getting older. And honestly, I'm concerned the hearing aids will make me feel and look older, too.*

The dispensing professional shifted her focus to evaluate Mrs Smith's intention to change:

Some Philosophical Approaches to Patients/Clients

Medical Model

The Medical Model is the traditional professional-patient approach based on history, chief complaints, clinical signs, and symptoms. A diagnosis is rendered and management therapies and techniques are revealed and offered to the patient. In the Medical Model, the practitioner is the expert supplier of advanced knowledge, while the patient is the recipient of the information.[8]

Research has shown patients recall only one half of the information presented, and of the other half, 50% of the recalled information is recalled incorrectly.[9] Additionally, with certain physical problems, such as obesity and diabetes, recall can be remarkably lower.

Audiogram Review

The Audiogram Review approach is essentially the Medical Model specifically applied to hearing loss patients. When using this approach, the professional explains red and blue circles and squares; vowels and consonants with respect to low- and high-frequency sounds; Speech Reception Thresholds (SRTs) and Word Recognition Scores (WRSs); normal, mild, moderate, severe, and profound hearing loss categories; decibels versus percentages; differences between air and bone conduction, and sensorineural versus conductive hearing loss; as well as other audiologic phenomena. These data-based explanations are often not useful, and arguably confuse and frustrate the patient.

Social Model

The Social Model addresses disability as the result of physical, organizational, and attitudinal barriers and presents disability as the result of societal discrimination.[10] The Social Model proposes that, if barriers were removed from society (ie, with respect to education, communication, work environments, transportation, housing, etc), the disability would become relatively inconsequential.

See "Counseling Approaches" for additional information on:

- Eclectic Therapy
- Brief Therapies
- Gestalt Therapy
- Person-Centered Therapy (Rogerian)
- Adlerian Therapy
- Psychoanalytic Therapy
- Behavioral Therapy
- Cognitive Therapy

Q Mrs Smith, if you don't mind, let me ask a few more questions. Is there anything about your hearing loss or your difficulty hearing that makes you think that you may need to get hearing aids?

A *Yes. Certainly the results of the hearing test today and the difficulties I've been having make me think hearing aids may help me hear better.*

Q OK, and if you were successful with your hearing aids, and if things worked out really well, what would be different?

A *I'd be able to hear. I'd be able to play bridge with my friends, even with the stereo on.*

Q What encourages you about hearing aids? What things would you enjoy if the hearing aids worked out?

A *Well, I see the new hearing aid styles are nicer than I imagined, so I'm not really too concerned about my appearance. I guess I'm also encouraged to consider that I could hear better if things worked out.*

Q What would be the best results you could imagine if you got hearing aids?

A *The best result would be hearing without thinking! If I can wear the little hidden hearing aids, and if they match my hair so nobody sees them, and if I can hear when we play bridge, that would be great!*

Finally, to elicit Mrs Smith's self-efficacy to change, the dispensing professional continued, asking:

Q What might stand in your way of getting hearing aids?

A *I suppose the biggest issue is the cost. But, then again, I really don't want people staring at my hearing aids and thinking I'm old and frail.*

Q What are the options for you now? What do you think makes the most sense?

A *I think I might be willing to try hearing aids. I'd like to see if they can solve the problems I've been experiencing. I definitely will not wear the giant ones, but if I can wear the little colorful ones, that would be something I'd be willing to try.*

With the complexity of the decision to purchase hearing aids "on the table," the dispensing professional affirmed and validated Mrs Smith's ambivalence. In some respects, her ambivalence was "operationalized" as balancing cost, cosmetics, and negative feelings from others, against enjoying cards and shopping and being able to shop and dine with friends whenever she wants to.

Validating the Emotional Experience

Anger and fear are close cousins. And, as demonstrated in the above example, both are apparent for people experiencing major loss(es). In the cases of acute, acquired hearing loss, emotions may erupt suddenly, often without warning. In the case of longstanding hearing loss, emotions may by fueled by memories of mothers and fathers, or grandmothers and grandfathers, wearing highly visible hearing aids, sometimes with little success.

Discussion. The core concepts of MI include rolling with the patient's resistance, enhancing the intrinsic motivation to change, and helping the patient articulate and discuss their reasons to change behaviors—all in a nonconfrontational atmosphere.

Presenting patients with facts and test results may appear to professionals as obvious choices, but too many facts and test data can confuse patients. In hearing care, as is often the case in medicine, we tend to give patients too much information. In doing so, we inadvertently increase their resistance. Of course, it is often our obligation to deliver test results and facts. However, to do this without addressing their ambivalence may lead to insurmountable inaction. To effectively reach the goal (ie, the patient deciding to change), dispensing professionals need to use strategic, open-ended questions and directed discourse to elicit the four categories of self-motivational statements from the patient, from which aural rehabilitation can begin.

The patient must "take ownership" of their hearing loss.[6] The patient needs to believe they can and would like to change their hearing status. To do so, they must experience the deficits associated with hearing loss

before they are willing to do the work or make the changes associated with effective aural rehabilitation via amplification.[7]

Lastly, it is important to realize that we, as hearing care professionals, don't usually see the really hard cases. In other words, those with the most "emotional baggage" related to hearing loss and ambivalence simply will not walk through the door. Rather, they tend to stay away.

In general, dispensing professionals see patients who have *elected* to come through the door—for whatever reason. If managed and counseled effectively using MI, these patients have an excellent chance of seeking amplification, as they are often on the verge of change and they are (in many respects) pursuing positive personal choices.

References

1. Amlani AM. Impact of elasticity of demand on price in the hearing aid market. Available at: www.audiologyonline.com/articles/article_detail.asp?article_id=1757; Accessed September 20, 2007.
2. American Psychological Association (APA). Dictionary.com Unabridged (v 1.1). Available at: dictionary.reference.com/browse/ambivalence. Accessed August 08, 2007.
3. Centers for Disease Control and Prevention (CDC). WISEWOMAN uses motivational interviewing to help Alaska Native women quit tobacco. *WiseWoman*. 2005. Available at: www.cdc.gov/wisewoman/pdf/vol_2/success_2.pdf. Accessed September 20, 2007.
4. Rollnick S, Miller WR. What is Motivational Interviewing? *Behav Cognitive Psychother*. 1995;23:325-334. Available at: www. motivationalinterview.org/clinical/whatismi.html. Accessed September 20, 2007.
5. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*. 2nd ed. New York: Guilford Press; 2002.
6. Harvey M. Motivational interviewing. Oticon Clinical Update. No 1, 2007. Available at: www.oticonusa.com/eprise/main/SiteGen/Uploads/Public/Downloads_Oticon/Oticon_Clinical_Updates/Motivational_Interviewing_OCU2.pdf. Accessed September 20, 2007.
7. Beck DL. Identifying the time for improved hearing. Oticon Clinical Update, No 1, 2007. Available at: www.oticonusa.com/eprise/main/SiteGen/Uploads/Public/Downloads_Oticon/Oticon_Clinical_Updates/Identifying_the_Time_OCU_2.pdf. Accessed September 20, 2007.
8. Wikipedia. Medical model. Available at: en.wikipedia.org/wiki/Medical_model. Accessed September 20, 2007.
9. Margolis RH. Page ten: What do your patients remember? *Hear Jour*. 2004;57(6):10-17.
10. The Open University. Social Model. Available at: www.open.ac.uk/inclusiveteaching/pages/understanding-and-awareness/social-model.php. Accessed September 20, 2007.
11. Allaboutcounseling.com. Counseling Approaches. Available at: www.allabout counseling.com/counseling_approaches.htm. Accessed September 20, 2007.