Motivating the Older Patient to Take Action

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Editor's Note:

This is part of a series of six expert seminar presentations and articles on the human side of the fitting process. This series is being presented throughout 2009, and is designed to walk through the hearing aid fitting process from beginning to end with a focus on the human factors that are at play each step along the way. Tools and strategies will be discussed that can assist in ensuring that the patient receives the optimal benefit from modern hearing aid technology. It is designed to be a complement to more typical discussions of hearing aid technology and fitting verification. Please see the accompanying recorded seminar on this topic in the AudiologyOnline eLearning library. Further courses in this series, "Managing Patient Expectations" and "Customizing Advanced Technology Fittings" can also be found as recorded and text-based courses in the AudiologyOnline eLearning library. Look for upcoming live courses in this series - Special Fitting Considerations, the Fine Tuning Process, and the Follow-up Process - that will be presented on 9/11/09, 10/30/09 and 12/4/09. Further details can be found in the AudiologyOnline course listings.

Introduction

The decision to use hearing aids by a new patient is just that – a decision. That decision belongs to the potential user and it is well documented that many will choose not to pursue this course. If we believe that there is a good chance that a patient will benefit from the use of amplification but we also sense that the patient is resistant to the idea, we have a clinical responsibility to help move the patient toward the decision to accept technology as part of the recommended treatment plan.

Although presbycusis is not the only cause of hearing loss in adults, it certainly is perceived by the general public that "hearing loss is something that happens to old people". What audiologists sometimes lose sight of is that hearing loss is not the only health issue that faces the older person. The human body experiences age-related changes in nearly all aspects of form and function. Although we may view hearing loss in isolation, the patient may not. Hearing loss may be perceived as just another aspect of inevitable body decline. The patient's reaction to the emergence of hearing loss may be tied to a broader, generalized reaction to the physiological effects of aging.

There is a significant body of literature that has been developed by other health care and behavioral scientific fields that speaks to the emotional reaction to the aging process. Audiology is not the only field that witnesses reluctance of older patients to take positive steps towards dealing with age-related body changes. The lessons learned by these related fields provide us some with some interesting insight in interacting with these patients.

The Emergence of Hearing Loss

Age-related hearing loss comes on gradually, often over the course of years or even decades. The effects on communication may increase so subtly that it will take time for some patients to even realize that they have hearing loss. This reality complicates the process by which a patient makes the decision to act. There is not a set point in time when it is clear that a health change has occurred and needs to be evaluated and treated. Although we will see the patient clinically after some combination of influences have acted to bring the patient to the audiology facility, the patient may be far from total acceptance of the hearing loss.

Engelund (2006) conducted a series of in-depth interviews with hearing-impaired patients. She sought to better understand the course that they went through that brought them to the point of seeking evaluation and, perhaps, treatment. She postulates that the decision to take action is driven by a confluence of three factors: the severity of the hearing problems; an awareness of the presence of hearing loss and the implications; and what is referred to as "moments of tribulation". "Moments of tribulation" are occurrences when the hearing loss causes frustration, embarrassment and problems with relationships. Having a hearing loss and being aware of it is not enough for a patient to seek evaluation or treatment. There also needs to be enough

negative experiences to motivate a person to take the first formal step into the hearing health care process.

Agreeing to have an audiological evaluation is not the same as being fully prepared to enter the hearing aid process. Every audiologist knows that many patients enter the diagnostic phase looking for an authority figure to tell them that they do not need amplification. Although the patient may have faced many moments of tribulation, frequently the patient is looking for some other explanation or course of action rather than amplification. Once a hearing loss is established and a recommendation for amplification is made, there are personality factors such as locus of control that will influence the older patient's willingness to follow those recommendations (Garstecki & Erler, 1998). The desire to appease a spouse or other family members who insist that the patient have a hearing evaluation may underlie the patient's visit to the facility. There may not be a sincere willingness to listen to the options posed by the audiologist and follow the recommendation to pursue amplification (if one is made).

Another important factor for the audiologist to consider is where hearing loss falls in terms of timing in the progression of overall age-related body changes. It turns out that hearing loss often falls relatively late in the list of common aging phenomena. Grey hair, farsightedness, loss of muscle mass, loss of flexibility, arthritis, weight gain, hypertension, dangerous cholesterol levels, menopause, impotence, and other age related changes may occur before hearing loss. The simple reality is that hearing loss can be ignored, and even more so if it is one of the later age related changes experienced by a patient. Hearing loss is not life threatening. If the patient is dealing with hearing loss after having already dealt with a long list of other medical issues, hearing loss may be the one condition the patient decides to ignore.

Reacting to Changes

Humans have a need to be able to control their environment: to be able to clothe, feed and entertain themselves. One effect of aging is to alter the person's ability to exert control over his or her world. As your vision changes, it is harder to read the newspaper. As you lose strength and stability, walking up and down stairs is a challenge. As your vision, reaction time and cognitive awareness falter, you can no longer drive safely.

Primary control mechanisms are our physical abilities that allow us to control our environment. Secondary control mechanisms are those strategies, devices and other assistance that an aging person can call upon to replace faltering primary control mechanisms: eyeglasses, walkers, blood glucose monitors, assisted care centers and, of course, hearing aids (McConatha & Huba, 1999; Wahl, 2001). The willingness and ability to adopt secondary control mechanisms is considered to be a sign that a person is aging successfully (effectively managing the inevitable physical and life changes that accompany the aging process). Not all individuals show a willingness to turn to secondary control mechanisms. A vital role that the audiologist can play is in maximizing the likelihood that the patient will be willing to adopt the secondary control mechanism of amplification. A key to the success of this strategy is approaching the task within a broader framework of life change in the patient, or considering the reaction to wearing amplification within a larger context of the reaction to aging.

Aging will challenge a person's sense of self worth. As the years progress and the physical effects of aging take hold, the roles that a person has always played may start to change. Lifestyle changes are inevitable. Some tasks will become more difficult. Some favorite activities may have to be abandoned. Mental health care professionals emphasize the importance of a healthy self-identity in the aging person, as strong mental health has been tied to physical well-being (Skaff, 2007). The decline in hearing abilities is another one of the challenges to a person's sense of self.

Whitbourne (2002) presents an important model of self-identity in the older person. She discusses what happens when a person is challenged with new information that is contrary to their perception of themselves. Imagine an older gentleman who has always prided himself on being able to walk 18 holes of golf. Over the past few years that task has become harder and harder to the point where he now uses a golf cart. If an important part of this person's self-identity is the image of an athlete whose has always been active in sports and other outdoor activities, the loss of the ability to walk the golf course now poses a challenge to this man's self-identity.

Whitbourne (2002) describes two types of reactions. One is Identity Assimilation, which describes the process by which this new data (the need for a golf cart) is made to fit within the person's existing belief structure about himself. The need for the golf cart is attributed to an accumulation of sports related injuries over the years that have now caught up to this active person. In our field, this shows up as the classic "young people mumble" explanation of communication difficulties.

The other reaction pattern is called Identity Accommodation, which describes the process by which the new data causes the person to change his or her self concept. The need for the golf cart is attributed to age-related changes in strength, flexibility and endurance: "I guess I am not as young as I used to be."

There are both positive and negative implications to either reaction pattern. Identity Assimilation may seem as if the person is not accepting the inevitable changes that come with aging, however it also indicates a willingness to not give in to aging and to take the steps to remain active. Identity Accommodation indicates a realistic mindset about the effects of aging but also presents the danger that the person will simply give in to the inevitable and start withdrawing from activities that have always been important and enjoyable. In our field, the danger is that the older person will decide to give up certain work or social activities because communication is just too difficult.

Identity Assimilation can be thought of a variation of the defense mechanism of Denial. Although we often see denial as a barrier to the use of amplification, it is vital that we remember that denial and other defense mechanisms exist for a purpose: to buffer a person who is not yet able to emotionally deal with some life event. Citing the importance of a strong, positive self-identity, Whitbourne (2002) points out that there is nothing wrong with a person reacting in line with Identity Assimilation as long as that person is willing to take positive steps towards dealing with the effects of aging. The person's reasons for action do not have to be fully in line with reality. A little bit of self delusion is fine, as long as the end result is a positive movement forward. If the patient wants to believe that using hearing aids is needed because young people mumble, where's the harm? The important point is that the person has taken action to maintain important connections with the world – a vital aspect of maintaining a strong sense of self.

Patient-generated Change

When discussing amplification with a new patient, a classic approach is to relate the expected benefit of amplification to the communicative problems identified by the patient. The emphasis is on the expected functional outcome. This approach is certainly more patient-centered than an approach that is focused on explaining hearing aid technology. Of course, there may be a need to explain how hearing aid signal processing works, as long as that discussion is given at a sophistication level that the patient can appreciate and that the technology is related to the communication challenge faced by the patient.

For a new user who is clearly ready and motivated to use amplification, discussing the benefits of amplification makes a lot of sense. This method is also appropriate for existing users who are interested in improving their performance with hearing aids. However, for a reluctant new user that the audiologist strongly suspects is not yet ready to embrace amplification, this approach may not be effective. Discussion of what the hearing aids will do for the patient may be premature if the patient is not yet ready to accept that anything needs to be done. In these instances, a modification of the classic, functional outcome approach is in order.

For these reluctant patients, the first step is to create the clear perception of need. According to Whitbourne's Identity Assimilation versus Identity Accommodation, establishing this need does not require the patient to fully accept the fact that the communication difficulties are due to age-related hearing changes. What is more important is that the person genuinely states that there is an important but unmet need in their life. Admitting that communication difficulties occur is not the same as expressing the desire to improve them. Creating a patient-perceived need for change requires the audiologist to use best practice counseling skills.

Miller and Rollnick (2002) present an intervention strategy that has been proven effective in a

broad range of conditions such as drug addiction, alcoholism, smoking, and others that require a person to make a decision to change health behavior. Motivational Interviewing is a patient-centered counseling approach that places emphasis on the patient describing unmet needs and goals. The professional then helps to create potential paths of action based on these goals. The key is that the establishment of the goals and the selection of a course of action to meet the goals must come from the patient, not as a prescription from the professional. The role of the professional is to facilitate the patient's establishment of goals and to help make paths to success clear.

Goal-based patient counseling is not new to our field. Dillon, James and Ginis (1997) introduced an important counseling tool to the dispensing audiologist more than a decade ago. The Client Oriented Scale of Improvement (COSI) places emphasis on structuring the rehabilitative process around the stated goals of the patient. This tool is well in line with the concepts behind Motivational Interviewing. The rehabilitative process runs the best chance of success when it is structured around the personal goals of the patient. The application of the COSI, however, needs to be adapted to the mindset of the patient. For the existing user or the willing new user, goal establishment for the COSI can occur reasonably quickly and can form a guideline to the choice of new hearing aids. However, for the reluctant new user, it is important to not rush into the process of goal establishment. In line with Motivational Interviewing, the establishment of unmet needs is a major milestone in the course of acceptance by the patient. It is an indicator that the patient is moving from resistance to establishing a self-stated reason for making a change. If the audiologist moves too quickly to establish COSI goals, those goals may not be genuinely felt by the patient. They may simply be a listing of situations in which there is communication failure. Those are not unmet needs because they lack emotional relevance to the patient. Completing the COSI too quickly may actually be counterproductive if it allows the patient to continue to distance himself from the problem.

Miller and Rollnick (2002) stress the importance of reducing ambivalence in the patient's mind. Often, lack of action by the patient is not based on denial that problems exist, but rather on not seeing a clear path to meeting those needs. In audiology, any doubts or misconceptions about the potential problems with amplification, questions about from whom to seek treatment, and concerns about cost versus benefit of hearing aids can all stand in the way of the patient moving forward with amplification. Communication difficulties may be acknowledged, but if the patient has many questions about that the right way to proceed, the defacto choice may be to do nothing. Ambivalence may become especially acute in older patients who have been experiencing an ever decreasing sense of value and influence as family members take over more and more of the day to day decision making. The audiologist needs to carefully walk the fine line between making a firm treatment recommendation and presenting the patient with an unsorted myriad of options. Professional guidance is essential, yet the ultimate ownership of the decision to follow through on treatment must always lie with the patient.

As stated earlier, amplification is a form of secondary control mechanism. McConatha & Huba (1999) point out a strong link between the adoption of secondary control mechanisms and a sense of self confidence and self worth in older individuals. Both George (2001) and Leventhal, Rabin, Leventhal & Burns (2001) stress that self-efficacy (the belief that a person has the ability to successfully perform a task or meet a goal) is an important component to making a successful health care change in older patients. In terms of amplification, the audiologist plays the key role in facilitating the patient's desire to make a change and in inspiring confidence that change is possible.

Final Thoughts

Our goal as a profession is to minimize the effects of hearing loss on the lives of our patients. For most adult patients, the provision of hearing aids is a key part of our arsenal. Effectively fitting amplification requires a breadth of technical and clinical skills. We require a deep understanding of both sensorineural hearing loss as well as hearing aid technology. We also have the responsibility to understand the psychology of the older patient.

No person should be fit with amplification who does not have an audiological need. What becomes more of a dilemma is how to respond to the large number of patients who, audiologically, would likely benefit from amplification but who are not yet ready to accept this course of action. Do we wait until they are fully self-motivated or do we intervene and move

them to a point where they take the step sooner than they would if left alone?

Given the well documented mindset of many persons facing the prospect of using hearing aids, we have the professional responsibility to use our best skills to move reluctant patients toward the use of amplification. The linkage in most people's mind between aging and the use of hearing aids is undeniable and can be strong enough to keep a person from taking appropriate action in response to communication difficulties. The audiologist has the role of refocusing attention from the cause of the loss and its association to aging to the role that amplification can play in addressing the emotional issues created by those communication problems. One hallmark of successful aging is the willingness for the older patient to take the initiative to adopt secondary control mechanisms in order to maintain important abilities, activities and relationships. Careful guidance on the part of the audiologist can engender this positive adaptive behavior on the part of our patients.

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