A U D I O L O G I C A L   R E S E A R C H   D O C U M E N T A T I O N

News from Oticon

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Aging & Health Care Decision Making

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Introduction

Introduction

It is no secret that hearing tends to decline as a person ages. Although the percentage of hearing impaired patients who accept hearing aids increases with age, there is still a large population of untreated persons in the fourth, fifth and sixth decades of life (Kochkin, 2005). Hearing loss is non-life threatening. The decision to use amplification is, indeed, voluntary. As a field, we have struggled with getting more and more individuals to be willing to use hearing aids as a treatment for age-related hearing loss. However, there have been only a few serious attempts in our literature (e.g., Garstecki & Erler, 1998; Cox, Alexander & Gray, 2005; Traynor, 2004) to understand the personality characteristics and motivational factors of those who consciously decide to deny or delay the use of amplification.

Hearing is not the only bodily function that declines over the years. A variety of other health professionals also deal with the situation of individuals having trouble constructively coping with the health changes that accompany aging. There is a broad literature that has been developed outside of the field of Audiology which studies the psychological and sociological factors that influence a person’s reaction to the health implications of aging. Excellent overview compilations are available from, for example, Binstock & George (2001) and Birren & Schaie (2001). As a field, we can learn from those other professionals who must also deal with the aging patient.

The Aging Body

Hearing Loss in Perspective

> *“Wearing a hearing aid makes me feel like I would feel older than I am.* ***I’m turning gray, loosing my hair, I can’t run anymore so that would just be one other thing added on.*** *Though I don’t care about turning gray or loosing – I mean I care about it but I’m not going to get a toupee or dye my hair.* ***I guess the hearing aid just layers on the feeling of getting old.****”* Olson Zaltman Associates (2005)

Our bodies age across the entire span of adulthood. The quote above is from a middle-aged individual who has a documented hearing loss, was encouraged to use amplification by an audiologist but still decided to remain unaided. As audiologists, we will see a new patient at one particular point in time.

Facing Aging

We document a loss and suggest a logical treatment. Sometimes we forget a few important things. Most importantly, hearing loss is probably not the only age-related change experienced by the patient. In fact, when compared to things such as vision loss, hair loss, muscle loss, arthritis, menopause, sexual dysfunction, slowing metabolism, etc., hearing loss may manifest itself relatively late in the process.

Perhaps the reluctance of a person to act on their hearing loss may be related to a general fatigue of dealing with the aging process: it is just one more thing that reminds them of their mortality. When faced with the need to make an age-related health change, there are a broad range of factors that will lead a person to either take action or not. (Leventhal et al. 2001). These factors are not just as obvious as symptom severity and access, but also include cultural, familial, life-experience, and identity issues. In our zeal to treat communication difficulties, we may forget that hearing loss may mean more than just difficult conversations in noise for some patients. It may strike at a much deeper, emotional level.

Aging and Self-identity

We all have an image of ourselves: our strengths, our weaknesses, our talents and our shortcomings. Maintaining a positive self-identity is an essential part of a well-adjusted response to aging (Whitbourne, 2002). When aging individuals are faced with facts that are not consistent with the image of themselves – “I can’t walk 18 holes of golf anymore”, “I can’t safely drive on the expressway”, “I keep forgetting where I park my car at the mall” – they can have one of two reactions (Whitbourne, 2002). Either they can adopt a strategy of ***Identity Assimilation***, in which they new facts are interpreted in a way that does not change their self-identity: “People with those big SUVs are driving faster and faster all of the time”. Alternately, they can adopt a strategy of ***Identity Accommodation***, in which they change their self perception to fit the new reality: “I guess my reflexes are just starting to slow down”.

Whitbourne (2002) points out that there are positive and negative aspects of both reactions. For individuals who respond with Identity Assimilation, the positive is that they will tend to adopt habits to keep themselves young. The negative is that they may refuse necessary medical attention because “that is what old people do”. Obviously, audiologists see a lot of patients where Identity Assimilation is the response: “Young people these days talks so fast”.

In contrast, the positive aspect of Identity Accommodation is that the patient tends to be more likely to accept health advice and intervention. However, the negative, if taken to the extreme, is that the patient will view health declines associated with aging as inevitable and may not be motivated enough to act on their health concerns.

Motivational Interviewing seems like the sort of technique that would help for patients who are not in a position to effectively deal with hearing loss. Like with the COSI (Dillon, James & Ginis, 1997), it is based on having the patient lay out clear and specific goals. But unlike the COSI, in which the stated goals are then used as the benchmark of success, with Motivational Interviewing, ***establishing the goals is a key milestone***. For patients who are either unwilling or unable to accept the reality of their hearing loss or for patients who passively accept communication difficulties as an inevitability of aging, even discussing goals can be difficult. A clinician who is well-versed in this counseling approach can get the patient to a point where they can be ready to start embracing change.

Final Thoughts

Audiologists have the desire to help patients solve their communication problems. Our natural tendency is to focus on the benefits that amplification can provide. In the broader view, however, we also have to keep hearing loss in perspective of the total life experiences of the patient – both in reference to other health issues they are currently facing and also health challenges they have faced over the years. Patients who have accepted their hearing status and are motivated to take action want to understand features and benefits. On the other hand, it is clear that some individuals are not yet at the point of talking about what amplification does.

Viewing hearing loss within the broader frame of life change helps to direct our role with each separate patient. There are lessons about aging that we can learn from our colleagues in the fields of psychology and sociology. Our natural tendency is still the same: to help those with hearing loss communicate more effectively. Our strategy becomes more differentiated, understanding where the patient is at this moment in time and what it will take to move forward.

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reality of the physical changes that accompany aging. She describes Identity Balance as the state in which the patient has a realistic enough recognition of the age-related health decline but does not go to the extreme of passive acceptance (Leventhal & Prohaska, 1986). They are the ones who are willing to adopt Secondary Control Mechanisms. In our case, of course, that means amplification and the related rehabilitative services.

Beliefs about Amplification

Functional Benefit

In the clinical environment, we have typically reacted to patient reluctance by stressing how much better they will perform with the use of amplification. It is not surprising that we follow that course. Hearing aids are always talked about in terms of what the technology can do for the patient. When we see **well-adjusted** patients in follow-up, they commonly talk about how much better they are performing. It is not unusual to hear the comment "the best decision I ever made".

The key, of course, is that these patients are well-adjusted. If they ever had difficulties with the thought of hearing loss as a sign of aging, they have moved past that point. They have accepted the reality of a Secondary Control Mechanism and are now focused on the functional outcome. The problem is that some patients who are earlier in the process may simply not be ready to see how much better life could be. They are still working through issues of self-identity.

Plannerzone, Inc. (2005) conducted focus group meetings for, among other groups, individuals who suspected that they had hearing loss but had yet to seek out treatment. They were asked to discuss their impressions of hearing aids. Table 1 provides a sampling of their thoughts and feelings. It is clear that, for whatever reason, these individuals are not focused on what positive things hearing aids can do for them. They are focused on all of the downsides, especially the aspects related to what a hearing says about them.

Table 1

What they "think about hearing aids"	What they "feel about hearing aids"
• Don't work. • Bothersome process. • Impaired; disabled; feeble. • Device is ugly; unsightly; gross. • Person wearing is less than perfect. • Expensive. • Only for some. • Only partial improvement. • "I am concerned with my vanity."	• Another daily chore. • Another doctor to see. • Requires routine maintenance. • Helpful to some (…but probably not for me…) • Only slight improvement. • Makes one appear feeble. *Plannerzone, Inc. (2005)*

The Olson Zaltman group (2005) report on in-depth interviews with patients points out an important issue for many individuals who are still rejecting the idea of using amplification: no matter how good the functional outcome of using amplification, at a deep level the hearing aid is a constant reminder to the patient and the outside world that "I am flawed". Hearing loss is viewed by some as loss of the ideal self: a decline, a failure. The use of hearing aids simply points a spotlight on that weakness on a constant basis.

> *"I don't want to wear one. I know they've come a long way as far as the type that you can't see and that type of thing. I guess it's just like a kind of manly, masculine –* ***it would be like a weakness. Probably because it's something that's going to help me with something that I can't help and I'm like an over-achiever type of person, and I want to do things on my own*** *and work things out on my own with no help, and to me, that's helping me,* ***so, it's something giving me help and I don't like that."*** Olson Zaltman Associates (2005)

Making Health Changes

As discussed previously, audiology is not alone in facing aging patients who are reluctant to make a health care change. George (2001) presents the Health Belief Model which lays out the criteria that must be met in order for an older individual to take action. The five criteria are as follows:

- Susceptibility (can it happen to me?)
- Symptom severity
- Perceived (expected) benefits
- Perceived (expected) costs
- Self-efficacy

As audiologists, we typically focus on the middle three: need (as we define it) balanced against the cost-benefit relationship. However, the other two factors can be crucial to patient motivation.

Hearing loss develops in nearly all patients slowly over a number of years. The audiogram that we establish on the first day we see a patient does not reflect the process that they have gone through up to that point in time. Engelund (2006) points out that patients must initially become aware that hearing loss can even be an issue (in George's terminology, "Susceptibility"). It may seem odd to us because hearing is our profession. However, the gradual onset and progression of hearing loss can be so subtle that a person who is having communication difficulties simply may not consciously consider hearing loss as an explanation. In Whitbourne's viewpoint, this would be seen as a case of unconscious Identity Assimilation.

Willingness to take action is also affected by the patient's confidence that they can make a change successfully (self-efficacy). Again, as audiologists, this notion

may seem odd to us. However, in other health care arenas such as weight control, smoking cessation, etc., the person must have the confidence that they can make the needed adjustments in their lives. ***We*** may not think that becoming a hearing aid user requires a lot from the patient, but ***the patient*** may. If the patient has had problems in the past making important life changes, they may see hearing aid use as another challenge that they cannot face.

Making Changes

Intervention Options

With the backdrop of hearing loss as another age-related health challenge, how can we move patients who are either so resistive to facing aging or, on the other extreme, so passive about taking action to a place where they are willing to adopt the secondary control mechanism of amplification? There are options.

One approach is to confront the patient with the data. Show him/her the audiogram. Measure the signal-to-noise ratio loss. Prove to the patient that there is a problem that needs to be addressed. The failure of this strategy is that it is an intellectual approach to addressing what is likely an emotional problem. Patients who are either denying the possibility of age-related problems or who are normalizing the loss do not need more facts and figures. There reaction is not based on a lack of information. It is based on being emotionally unprepared to take constructive action.

An alternative approach is “positive personal choice”. Under this concept, the decision to pursue amplification must be an ***active decision on the part of the patient***. It is a contrast from the older, “Marcus Welby” approach of taking action because the medical professional says so. Rather, the patient takes ownership of the decision to make a life change.

An effective example of this approach, called ***Motivational Interviewing***, is described by Miller and Rollnick (2002). This is a short-term, patient-centered counseling technique developed for individuals who must change behavior in order to improve their health. Within the Motivational Interviewing technique, the patient makes the decision to change based on ***options*** and ***personal goals***. The key to the technique is to reduce ambivalence: uncertainty about the pros and cons of different courses of action often leads to inaction. The better able the clinician is at laying out options with clear consequences, both pro and con, the easier it is for the patient to commit to a course of action.

The Motivational Interviewing technique has been demonstrated to be effective in a variety of health behavior change contexts (i.e., drug use, alcohol use, weight control, etc.) The effectiveness of the Motivational Interviewing technique is indeed impressive, as these are areas in which long-term success is often hard to achieve using a broad range of other types of program (e.g., twelve step). This technique has also been discussed as an option within the realm of hearing impairment (Beck, 2004). More information, including links to documented effectiveness studies, can be found at www.motivationalinterview.org.

The Inevitability of Aging

> *“Well, I felt a little uneasy about it, but I think that everybody . . . has a problem with hearing everything. If your hearing is normal due to age, and you almost get everything, then I think it is needless to do anything more as long as you know that when it gets worse you can get some help. . .”*
>
> *“When I asked the neighbor what had been said then I realized that there were also other people who can’t hear, so I’m not the only one.”* Engelund, 2006

There is a well-documented (George, 2001) tendency that some older individuals, when faced with evidence of age-related health declines, will respond by adopting a ***Normalization*** strategy. These quotes are from hearing impaired individuals who were interviewed as part of an in-depth study (Engelund, 2006) on the time course over which people recognize the presence of hearing loss and become motivated enough to take action. When interpreting their health status, older individuals tend to compare themselves to peers, and not to how their health was when they were younger (Robinson-Whelen & Kiecolt-Glaser, 1997). It is always possible to find another person of the same age with worse hearing.

Although Identity Accommodation may be viewed as growing old gracefully, the downside is that the motivation to take charge and do something about the hearing loss may be lacking. Wahl (2001) views the response to aging in reference to ***Primary*** and ***Secondary Control Mechanisms***. Primary Control Mechanisms are those capacities and talents that allow us to control our environment. They allow us to lead our lives: clothe, feed and shelter ourselves, seek out social contact, entertain ourselves. When we lose some physical ability due to accident, illness or aging, we have the choice to adopt Secondary Control Mechanisms: adaptive technologies, strategies and behaviors that allow us to continue to do the things we have always done. Some aging individuals are more willing than others to adopt Secondary Control Mechanisms (Wahl, 2001).

Loss of Control

> ***“It’s part of me. Trying to be perfect*** *and it’s false, it’s not possible… I raised my children that way, to* ***work for the highest, to strive for the highest****. I didn’t acquire it but I wanted them to do so. But what I did I tried to do the best I could.* ***And I used to give up when I wasn’t coming up to my high standards.”*** Olson Zaltman Associates (2005)

As audiologists, we want our patients to have a realistic understanding of the realities of aging. Individuals who completely deny the presence of hearing difficulties are those who will not accept amplification because of its association with aging. However, we do not want them to go to the extreme of complete age normalization such that they do not want to even bother with amplification.

Whitbourne (2002) points out that Identity Assimilation or Accommodation are not static states. A person may very well change their reaction to aging over time. Rationalization or denial may be essential for some individuals as they adjust the