MOTIVATIONAL INTERVIEWING

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Motivational Interviewing (MI) has been successfully used across a multitude of health professions to address the issues of alcoholics, drug addicts, smokers, obese patients and more. MI has been successfully used by Hearing Care Professionals (HCPs) to facilitate the patient's discovery and elaboration of the patient's problem associated with hearing loss (Beck and Harvey, 2009).

MI might be thought of as intentional and strategic conversational engagement, between a patient and their HCP for the purpose of facilitating reasonable and achievable goals, stated and defined by the patient. The key here, is the *patient* discovers, elaborates and defines problems, not the hearing care professional (HCP). The HCP facilitates and applies course corrections as needed. Beck & Harvey (2009) suggested that to successfully use MI, the HCP must direct the conversational discourse to probe and reveal the desired outcomes from the patient's perspective. That is, the HCP

sets up the conversation such that the patient states the reasons to change his/her behavior (i.e., address hearing loss).

For many HCPs, using a traditional approach, some conversations are essentially non-productive, For example, the HCP might say something like, "your hearing loss is very common, you have a high frequency hearing loss, and hearing aids will make it easier for you to hear…" However, some patients might say, "I hear what I want to hear." Or, perhaps, "I hear pretty well most of the time." Or, the old standard, "My hearing isn't really the problem. The problem is my husband/wife speaks to me from the other side of the house while the TV is on and nobody could possibly understand a word that he/she said."

The common thread across the patient's responses (above) is the HCP allowed the patient to deny their hearing loss exists and the HCP allowed the patient to minimize the negative impact of her hearing loss on her quality of life (QOL). That's the problem with our traditional empathetic, Q&A approach.

With regard to MI, what the HCP should have done is direct the conversational discourse "to probe and reveal the desired outcomes" from the patient's perspective. The HCP should manage the conversation such that the patient states the problem(s) and the reason(s) to change (i.e., acquire hearing aids). And to be clear, when using motivational interviewing, the patient does most of the talking.

EXAMPLE ONE

Patient: My hearing is fine. The problem is my wife talks to me from the other side of the house, that's the real problem!

HCP: That must be difficult. So there are times when you simply cannot understand her, and sometimes it's because she's just too far away. How do you do in a noisy restaurant? If your wife's across the table and the restaurant is pretty full, can you understand every word?

Patient: Well, I understand most of the words and I can get by.

HCP: What about at a cocktail party? Suppose you've got an event like a holiday party and everyone's dressed up, everyone's talking at the same time, how do you do there?

Patient: Yeah, that can be a real problem.

HCP: And so what I've heard you say is that sometimes your wife's voice is really hard for you to understand, sometimes it can be difficult in restaurants and cocktails parties to follow the conversation, is that correct?

Patient: Yes, that's pretty much it. Most of the time I'm fine, but sometimes I have difficulty hearing.

HCP: And let's face it, your wife, the restaurant and the people at the cocktail party are not going to change…so what if we could make it easier for you to hear more clearly in those situations? Would that be something you'd be willing to try? And would your conversational experience be better if you understood more?

Traditionally, HCPs have been taught to ask lots of questions, all with good intention, yet some of these same questions might de-rail the entire visit.

For example, when we ask questions such as, "Are you concerned about your hearing loss?" The patient might say, "Not at all. I've had hearing loss since I was in the service, my father had hearing loss since he was in the service, it's just a part of life." As this conversation occurs, the patient is more or less stating he/she is accustomed to their hearing loss, it's the status quo, and from their stated perspective, it's fine. Participating in this conversation is not productive and indeed, it may be damaging. It allows the patient to minimize their hearing loss and the negative impact of the hearing loss on his/her quality of life. When the patient declares these things out loud, they hear themselves take an opinion and they tend to maintain and reinforce that same opinion, maintaining that their hearing loss is not an issue and it is not causing a problem.

The lesson is, we need to direct the conversational discourse so as to not allow the patient to deny their hearing loss or the impact of their hearing loss with regard to quality of their life.

Another question HCPs have been trained to ask is, "What brings you in today?" Many people say something like, "My husband thinks I can't hear him and I'm here just to prove my hearing is fine." Again, by asking this specific question we've allowed the patient to go negative, deny hearing loss and the impact of hearing loss, and to formulate a message to us, which they are very likely to reinforce and defend. Rather than listing questions which aren't beneficial, we'll review a few which are very helpful, just to give you the idea of what to ask and why.

Great Question:
Thanks for coming in today Mr. Smith. Before we do any testing, it's very helpful for me to know a little bit about the difficulty you're having so I can focus on that. In your experience, which is the worst situation for you…a loud and noisy cocktail party or a loud and noisy restaurant?

Rationale:
This is a great question because we almost don't care which answer the patient picks. The important thing is to control the conversational discourse and to ask questions from which the patient focuses on and speaks about difficult listening situations. That is, we've asked a specific question from which he is speaking about his hearing loss and the difficulty he has understanding in at least one, or perhaps both situations.

Great Question:
Thanks for coming in today Mr. Smith. Before we do any testing, it's very helpful for me to know a little bit about the difficulty you're having so I can focus on that. So then, how long have you had difficulty hearing?

Rationale:
Of course he might say, "I don't have difficulty hearing." However, the chances are quite good that as he is in your office, you're an HCP, and it clearly says HCP over the front door, he may say something like, "I've noticed that in some situations, even though I can hear people talking, I really cannot understand what they're saying." Of course, if he says something like that, the HCP using motivational interviewing might say something like, "Tell me more about the most difficult listening situations?" And then more, and more. The idea being to get the patient to explore and reveal a multitude (if possible) of situations in which he/she has difficulty hearing, and situations in which it would be better to communicate more effectively.

EXAMPLE TWO

Patient: I know my wife thinks I have hearing loss, but the problem is most people mumble. People just don't speak clearly anymore!

HCP: I hear that from a lot of patients. Let me ask you a couple of questions. First of all, whose voice is the hardest to hear, a young child, or a woman's voice?

Patient: Well that depends, but I guess a child's voice is harder.

HCP: And is it better or worse when the child is on the phone?

Patient: Much worse – that's a really difficult situation. When my daughter puts the grandkids on the phone, I can hardly understand a word they say!

HCP: Grandkids on the phone are very difficult. How do you do at family dinners, like at a birthday party, Thanksgiving or other family events?

Patient: Well you know, if the person talking looks up, or looks at me, and if they speak clearly and they don't mumble, I can get by just fine.

HCP: OK, so what you've told me is children's voices are difficult to understand, and they're even worse on the phone, and family events are sometimes challenging. What if we could improve your ability to understand on the phone, and made it easier to understand people speaking at family events, would that be worthwhile?

Patient: Absolutely!

Self-Motivational Statements:

Motivational interviewing is a protocol which is applicable to patients who come to your office while denying a hearing loss, or are ambivalent about following your recommendations. MI was originally designed for motivating people to recover from alcohol and drug dependence, as these people are typically highly resistant to maintaining abstinence, even in the face of reason or persuasion (Miller and Rollnick, 2002). Motivational interviewing is thought of as a brief intervention and, indeed, much can be accomplished to move a person toward healthy behavior change in a single session.

An important tool of motivational interviewing is the elicitation from patients of self- motivational statements or change talk. The following are four categories of self-motivational statements.

1. Problem recognition: e.g., "I guess there's more of a problem than I thought."
2. Expression of concern: e.g., "I'm really worried about…"
3. Intention to change: e.g., "I think it's time for me to…"
4. Degree of self-efficacy to change: e.g., "I think I can do it."

The following questions may be useful in eliciting conversational discourse to probe and reveal these self-motivational statements.

1. Problem Recognition
   a. "When did you first notice hearing loss?"
   b. "Where (or in what situations) do you notice your hearing loss the most?"
   c. "In what ways do you think other people (or you) have been affected by having a hearing loss?"

2. Expression of Concern
   a. "What worries you about hearing loss?"
   b. "How do you feel about having hearing loss?"
   c. "Where are you uncomfortable because of your hearing loss?

3. Intention to Change
   a. "What makes you think that you may need to get hearing aids?"
   b. "What would be the most important benefit of improving your hearing?"
   c. "How has your hearing loss stopped you from moving forward, from doing what's most important in your life?"

4. Degree of Self-Efficacy
   a. "Do you think it's possible to improve your hearing?"
   b. "What might stand in your way of improving your hearing?"
   c. "How would you like to proceed from here."

REFLECTIONS

The objective is to ask questions about the meaning and emotions that a patient attributes to hearing loss. The most important questions are those relating to one's motivation for treatment. Once those answers have been stated, the HCP may provide a summary of what the patient verbalized via reflective listening. As noted above, the patient should do most of the talking. Asking questions and listening to patients' responses are surprisingly simple.

As one professional stated, "What I continually try to teach young professionals is to be humble and to listen to the patients. Listen and reflect." It is not a good idea to listen with the goal of formulating a response; that's not really listening, that's strategizing. Ask questions, listen, be humble and reflect.

The following are reflections from audiologists who have learned to use MI.

> "When I first started fitting hearing aids, my first goal was to 'fix' the problem. I think in school we aren't taught to really listen to the patient and troubleshoot from all angles. All clinicians live in a hurried world of appointments and schedules and problems and we address what we perceive as the primary problems, instead of really listening to the patient."

There are three caveats to eliciting and reflecting back affect from patients. First, we can never totally empathize with another's experience. Each of us has different life experiences and lenses through which we experience life. Accordingly, the well-intentioned attempt to establish rapport by saying, "I know. I understand how you feel." is often experienced by the other as insulting and is met with anger and indignation. The second caveat is the importance of maintaining professional boundaries. Many HCPs are justifiably concerned about opening up a can

EXAMPLE THREE

Patient: Many of my friends with normal hearing avoid crowds and loud parties. Sure, I sometimes misunderstand what people are saying, but it's really no big deal.

HCP: You notice that you misunderstand people sometimes. What else have you noticed when you're in crowds with a lot of background noise? [Problem Recognition]

Patient: I don't want hearing aids. I know it helps and there's a hearing aid person near my house, but I don't want to be dependent on technology. It's just a crutch. When I went to the audiologist before, it made me uncomfortable.

HCP: I hear that a lot. It sounds like you know a bit about hearing aids and audiology. What do you already know about how it may be helpful to you? [Intention/ability to change]

Patient: I see a lot of people just nodding their heads at parties, pretending they understand. Sure, I may do that more than some people, but it's really no big deal.

HCP: You have the sense that you're kind of winging it – passing – more than others. How do you think that's affecting your quality of life? [Problem recognition, Expression of Concern]

of worms which one isn't qualified to handle. Third, there is limited appointment time. Today's HCPs are too often besieged by managed health-care driven hurried appointments and are pressured to get the job done as quickly as possible. Listening to a patient's feelings may seem like a laudable goal but it is often deemed superfluous and cumbersome. As one audiologist put it, "Given the constant barrage of rushed, back-to-back appointments – never mind the paperwork and billing hassles – I don't have the luxury of listening."

To address these three caveats, here are some potentially useful strategies to elicit a limited narrative of the patient's emotional world and self-motivational statements without opening up a can of worms.

> "In about a minute or two, can you give me a snapshot of how you're feeling about…"

> "We only have a few minutes, but can you give me a quick sense on what's going on?"

> "Would you tell me about a short vignette that would illustrate what you expect to happen between you and your husband/wife with and without hearing aids?"

> "Would you briefly give me an idea of how your hearing loss influences different areas of your life? For example, how does your hearing loss affect your relationships with others? Or, describe how your hearing loss is a part of who you are as a person?"

OBSERVATIONS

In the following scenario, an HCP is using MI to elicit and reflect back the patient's self-motivational statements, or change talk.

While engaged in motivational interviewing, the HCP did not challenge the patient. Rather, he simply used reflective listening to convey that he understood her sentiment and feelings. The HCP also did not barrage the patient with facts. Presenting patients with facts and test results may appear to professionals as obvious options and choices, yet too many facts and test results often confuse patients.

In audiology, as in medicine, we tend to give patients too much information, and in doing so, we inadvertently increase their confusion and resistance. Hence, the patient dynamic: "The doctor explains how treatment will help, which makes me angry, but I cannot show it because that will make the doctor talk more." Of course, often we must deliver test results and facts, but to do so without addressing their mixed feelings, may lead to insurmountable inaction (Beck, Harvey, & Schum, 2007).

In the words of Nietzsche, "Silence is poison."

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FINAL THOUGHTS

It is important to convey respect for a patient's ambivalence and to make their uncertainty part of a collaborative dialogue. Specifically, the critical task of the HCP is to deliberately amplify (pun intended) both sides of their indecisiveness; to elucidate the pros and cons about change verses no change, hearing aids verses no hearing aids; and to collaboratively assist in the decision making process.

Admittedly, MI can be tricky. One audiologist recently said, "I can see how motivational interviewing is effective, but it's cumbersome."

We agree. To the extent that it is an unfamiliar protocol for HCPs, it may feel cumbersome. Moreover, dealing with patients' emotions can be unpredictable and may be filled with hidden psychological land mines. As such, there are several possible logistic arrangements for audiology-psychology collaboration. An HCP may refer a distressed patient to a mental health clinician. However, due to the psychological issues inherent in making a referral, this must be handled very delicately so that the patient does not feel stigmatized or rejected. Another option is for the HCP to seek and receive psychological consultation about motivational interviewing and ways of navigating around emotional landmines when evaluating their patients. Finally, the HCP and a mental health professional may together and separately meet with the patient at select times during the diagnostic and treatment process. In general, HCPs see patients (who often have mixed feelings) who have elected to come through the door for whatever reason (Beck, Harvey, & Schum, 2007). If managed and counseled effectively using motivational interviewing, these patients have an excellent chance of seeking the needed amplification, as they are often on the verge of change and of pursuing positive personal choices. ■

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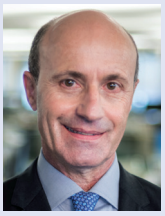

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