



# Creating Successful Professional-Patient Relationships

BY DOUGLAS L. BECK AND MICHAEL A. HARVEY



Photo Courtesy of NIDCD.

Of the more than 36 million people with hearing loss in the United States, hearing professionals only fit about 23 percent with hearing aid amplification. Even among these, some leave the office without doing anything. Perhaps they leave because we have not effectively connected with them, or perhaps we failed to understand their motivation, situation, or purpose. The goal of this article is to offer suggestions, concepts, and insights regarding patients who leave without doing anything.

Unfortunately, there's no Holy Grail in relationships. Sometimes patients seek professional help with problems for which the professional is well trained and competent, and sometimes they don't. Sometimes patients want help with their hearing problems but they're not sure they want to do the work or spend the time or money required to get the help they need. Each situation is unique. There's no "one size fits all" solution.

Beck et al (2007) noted professionals typically don't see the most difficult cases. That is, the ones that *really, really, really* are determined not to do anything about their hearing problems simply don't walk through the door. Generally, professionals only see patients who choose to come through the door. Hearing loss is the third most prevalent chronic health problem in the United States,

exceeded only by arthritis and hypertension (Chisolm et al, 2007). Nonetheless, of the more than 31 million people with hearing loss in the United States, hearing professionals only fit about 23 percent with hearing aid amplification (Hou and Dai, 2004; Kochkin, 2005). Therefore, some 77 percent of people with hearing loss are not receiving benefits from amplification and aural rehabilitation.

thinking, emotions, and cognition. Thus, connectivity is essentially a human experience. Connectivity may have been the essence of the famous Helen Keller quote, "Life has taught me that being blind separates me from things, but being deaf separates me from people."

Connectivity is so primary and basic that it often goes unnoticed when thoughts, feelings, emotions, and

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**Given that amplification devices enhance connectivity and improve people's quality of life, it follows that people with hearing loss should be banging on the audiologist's door! Unfortunately, most people who would benefit from amplification avoid the door at all costs.**

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The patients we'll address in this article are from the 23 percent we see. Even among these, some leave the office without doing anything. Perhaps they leave because we have not effectively connected with them, or perhaps we failed to understand their motivation, situation, or purpose. The goal of this article is to offer suggestions, concepts, and insights regarding patients who leave without doing anything. Unfortunately, if we don't do all we can to establish successful relationships with each patient, the result may be no relationship.

The three primary themes we'll address are connectivity, influence, and motivational interviewing. These are each somewhat intuitive, and many successful professionals use bits and pieces of these themes already. However, human interactions are diverse and complicated. The three themes are not mutually exclusive; they clearly interact, overlap, and intertwine. Acquiring a working knowledge of each allows us to be more cognizant of the invisible "forces" working for and against each professional-patient relationship.

### **Connectivity**

Beck and Harvey (2009) framed connectivity as a shared internal experience founded on listening, feeling,

cognitive activities are healthy and stable. However, when connectivity fails to operate normally due to hearing loss, or loss of emotional content, or reduced cognitive ability secondary to the aging process, the failures of each exacerbate the other, often resulting in "negative synergy" (Schum and Beck, 2008; Beck and Clark, 2009).

### **Connectivity and Untreated Hearing Loss**

When hearing loss is untreated, social phobias, depressive symptoms, and frustration and anger in relationships are likely (Harvey, 2001; Kochkin, 2006). Engelund (2006, p. 174) noted that untreated hearing loss can even threaten one's self identity.

Reduced connectivity often results in a reduced quality of life (QOL). Indeed, even pediatric patients have suffered negative QOL consequences secondary to hearing loss. In a study of 137 children, ages 8 to 17 years, treated for neuroblastoma, Gurney et al (2007) reported that children with hearing loss were at greatest risk for academic learning consequences as well as psychosocial difficulties and decreased self-reported QOL.

Engelund reported (see Beck, 2007) that if an individual does not self-identify as a person with hearing problems, they are unlikely to seek or welcome solutions to

hearing problems they neither recognize or acknowledge. Engelund (2006) addressed problem solving behaviors of hearing-impaired people and noted intentional change involves emotion, cognition, and behavior. Regarding the (approximate) four out of five of people with hearing loss who do not seek treatment, Engelund (2006) suggests that rather than viewing them as stigmatized or in denial, we (and they) would benefit from viewing them as being in different stages of the hearing loss recognition process and as needing different kinds of attention and rehabilitation. Not all people follow these stages step-by-step in a predictable or linear fashion. Some skip steps, and some repeat steps, and some get stuck in steps for extended periods of time, perhaps forever. Engelund's (2006) four stages of recognition of hearing loss are:

1. Attracting Attention (people with an emerging hearing problem)
2. Becoming Suspicious (people who start to think they *might* have hearing problems)
3. Sensing Tribulation (awareness of hearing loss and recognition of problems)
4. Jeopardizing Self (awareness of dangers related to untreated hearing loss and awareness that their QOL can suffer from untreated hearing loss).

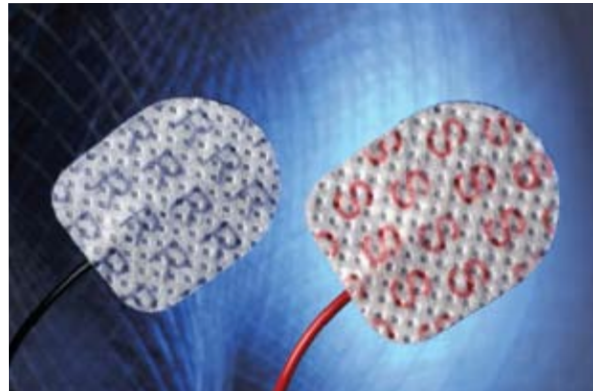
### Connectivity and Treated Hearing Loss

When hearing loss is treated via amplification, improvements in relationships as well as improved intimacy and warmth within family and group relationships are evident. From an individual psychological level, emotional stability and a sense of control tend to improve when amplification is employed to treat hearing loss.

In their comprehensive report, Chisolm et al (2007) addressed QOL as it relates to hearing aid amplification in adults. After systematic review and meta-analysis of 16 previous studies, the authors concluded that hearing aids do improve health-related QOL by reducing psychological, social, and emotional effects of sensorineural hearing loss.

As advanced amplification tools become commercially available, the opportunity for enhanced human connectivity and improved QOL also increases. When people connect seamlessly and wirelessly with ease and efficiency using intuitive and familiar tools, connectivity increases. Technical achievements that facilitate enhanced access between advanced hearing aids and more traditional

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devices (such as television and landline-based telephones) through wireless systems (i.e., Bluetooth, WiFi, near field magnetic induction [NFMI], and FM systems) are of paramount importance, as they facilitate increased connectivity.

In years past, audiologists provided hearing aid amplification and then also provided multiple assistive listening device (ALD) systems to allow patients to communicate

### Reciprocation

*Reciprocation* is the tendency to give back to others. In almost all human exchanges, when we give first, the other person is extremely likely to give back. If a friend or colleague offers you a service or acknowledgment, you're very likely to return the gesture. When someone extends their hand to you, you extend your hand and shake.

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**People prefer to engage with people they like.  
You must genuinely like your patients,  
and they must like you.**

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via telephone, watch television, and appreciate music. Unfortunately, the ALD system was often perceived by the patient as “just one more thing” to learn about, purchase, and figure out how to use. Patients often responded with “I’ll think about it,” and that was that. Now with integrated and wireless solutions to connect so many common sound sources to advanced hearing aids, connectivity has become seamless, easy, intuitive, and wireless and increases access to people.

### The Clear Dilemma

Given that amplification devices enhance connectivity and improve people’s quality of life, it follows that people with hearing loss should be banging on the audiologist’s door! Unfortunately, most people (perhaps 77 percent) who would benefit from amplification don’t actually bang on the door. Rather, they avoid the door at all costs. How can we influence or motivate those who request our assistance?

### Influence

The ethical use of influence relates to having integrity, placing the needs of the patient above the needs of the professional, and understanding how people think. In his books *Influence: Science and Practice* (2008) and in *Yes! 50 Scientifically Proven Ways to Be Persuasive* (2008), psychologist Robert Cialdini, PhD, and coauthors Goldstein and Martin addressed six primary principles of ethical influence. The principles are extraordinarily easy to understand, are universal across all human relationships, and can specifically be applied to audiology and aural rehabilitation. The six principles are reciprocation, scarcity, authority, consistency, liking, and consensus.

People like to, and people tend to, reciprocate.

Reciprocation occurs in marketing initiatives too. When charitable groups send direct mail appeals for financial support, the return rate often approaches 25 percent. To achieve this stellar response they often send along an almost insignificant packet of personalized address labels or similar trinket. As a result of receiving a gift, many people respond with a financial donation.

Perhaps an effective application of the reciprocation principle (with regard to amplification) is a trial period with advanced amplification and connectivity devices. When individuals experience positive life-changing benefits through advanced technology within their personal and daily lives, they are more likely to pursue these technologies than they would have been without experiencing the benefit firsthand. In other words, the offer of a trial and the trial itself represent the initial gesture from the professional to the patient.

### Scarcity

*Scarcity* is the tendency for people to want more of things they can only have less of. For example, rare coins, tickets to a sold-out Broadway show, Mickey Mantle or Babe Ruth baseball cards, never-opened original vinyl versions of The Beatles’s *Sgt. Pepper* album, and so on. People like rare, scarce, and unique. However, scarcity can go beyond physical items and may include unique or rare services combined with unique or rare products. For example, when advanced hearing products are introduced, professionals attend product-specific training to acquire knowledge to fit these products. The combination of a sophisticated product and a highly trained professional

may infer the scarcity principle. Thus, the hearing-care professional markets their advanced training in tandem with the new product. Dentists, optometrists, and ophthalmologists often market their talents combined with the latest tools in their professions, also.

**Authority**

Authority is straightforward. In essence, people like to know the professional they're working with is an authority within their profession and has impressive credentials. Physicians, dentists, and optometrists, as well as accountants, attorneys, psychologists, social workers, and cosmetologists, place their professionally framed credentials (diplomas, licenses, certificates, awards, etc.) in plain view. These credentials establish the professional as an educated person, a person with superior knowledge and talents—in brief, an authority.

**Consistency**

People's behavior tends to be consistent with what they say. This is a core tenet of motivational interviewing

(discussed below). Professionals must listen carefully and intentionally elicit patients' verbalizations. The words the patient chooses to articulate their intentions and abilities to change (e.g., seek amplification) reflect their own thoughts processes and intentions. When we successfully incorporate their wants and needs into an aural rehabilitation strategy, we increase the likelihood of connectivity and the chance that aural rehabilitation will progress and succeed.

**Liking (i.e., likability)**


People prefer to engage (or do business) with people they like. Conversely, they don't like to do business with people they don't like. If the professional or patient notices a sincere, real, or genuine reason to like the other person, it makes the relationship easier and makes connectivity more probable. There are two corollaries to the liking principle. First, you must genuinely like your patients, and second, they must like you. It is difficult to establish connectivity with people you don't like. Motivational interviewing (MI) is a counseling approach that is quiet

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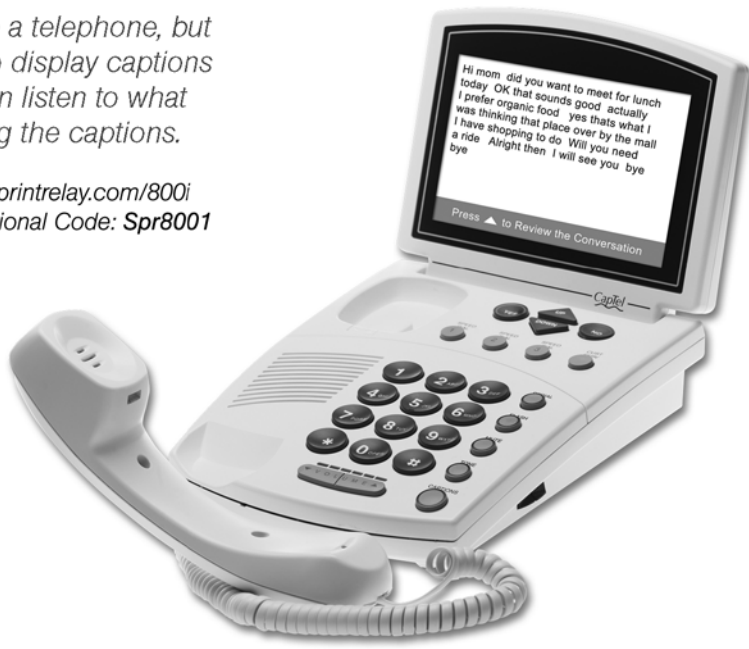
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and friendly, not threatening, domineering, or persuasive. As such, MI has the ability to enhance likability.

### Consensus

People generally look around to see what happened to others in similar situations. When faced with major medical decisions, all of us want to know the odds of success based on people who have been through it before. To address consensus, audiologists may provide written testimonials and photos in their waiting room, arranged in intuitive and easily navigable sections to make it easy for the patient to find others “just like me.”

### Motivational Interviewing

Motivational interviewing (MI) was originally developed as a goal-directed, patient-centered counseling tool to help alcoholics who had been resistant to change (Miller and Rollnick, 2002). MI has been successfully applied to smoking cessation, weight reduction, drug programs, and more (Centers for Disease Control and Prevention, 2005). MI might be thought of as a protocol designed to

maximize effective and appropriate influence management. To successfully use MI, the audiologist directs conversational discourse to probe and reveal the desired outcomes—as seen by the patient (Rubak et al, 2005; Beck et al, 2007; Harvey, 2007). In other words, the audiologist sets up a context in which the *patient* states the reasons for change.

There are four categories of self-motivational statements (i.e., “change talk”) that the professional elicits from the patient via purposeful questioning. *Problem recognition* might be as simple as asking the patient, “Is it more difficult for you to hear in a cocktail party or noisy restaurant?” An *expression of concern* might be elicited by asking, “Do you have concerns about what your friends might think if you wear hearing aids?” The *intention to change* might be evaluated by asking, “If the hearing aids really helped, can you imagine wearing them?” Lastly, the *degree of self-efficacy* to change can be elicited with “Do you think you’ll be able to wear hearing aids at work and at home?” An audiologist’s dream scenario would be for the patient to respond as such:

## Stages of Change

### Pre-contemplation

Patient denies the problem.

### Contemplation

Patient is ambivalent, considers change, rejects change.

### Determination

Patient’s motivational balance tips toward change.

### Action

May include hearing aid acquisition or aural rehabilitation.

### Maintenance

Help patient identify and use strategies to prevent relapse.

### Relapse

Help patient avoid demoralization of relapse.

Source: Prochaska et al, 1994.

Wow, I guess there's more of a problem than I thought and I'm really, really concerned about the effects of my hearing loss. I think it's way past time for me to address this, and I'm ready, willing, and able to do this as soon as you can fit me in your busy schedule! How can you help me?

Fantasy aside, change is not always linear (see Engelund, 2006). Patients often experience repetitive stages in the course of acknowledging and addressing a problem, sometimes beginning with denial.

It is a common phenomenon; when professionals are confronted with a patient "in denial," we become anxious. Then, to mitigate our anxiety, we talk more, lecture more, and use more impressive-sounding words. This strategy is very likely to backfire. As noted above, the patient and professional need to like each other. As our anxiety and syllable counts increase, our likeability index decreases. Professionals skilled in MI tend to talk less, ask more questions, and listen more. MI is a counseling style, and it is nonconfrontational.

The "Stages of Change" are summarized in the sidebar. (A similar illustration, the "Wheel of Change," appears in the following sources: Prochaska et al, 1994; Harvey, 2003a, 2003b; Beck et al, 2007; Harvey, 2008)

### Ambivalence and MI

Sigmund Freud may have had some strange ideas, but he was clearly correct when he said that every decision is characterized by some level of ambivalence. Ambivalence refers to the simultaneous feeling of wanting and not wanting something, a feeling of attraction and repulsion to the same thing. Ambivalence often means seeing the good and bad, the right and wrong, the advantages and disadvantages, while being uncertain as to which path to follow.

Freud's dictum is absolutely relevant to the task of health-care professionals. Our task is more than giving advice; our task includes *motivating* patients to do what's in their best interest. Sometimes, using traditional counseling techniques just gets one deeper and deeper into trouble. That is, when a professional voices one side of the patient's ambivalence (change), it precipitates the patient voicing the other side of ambivalence (no change). Indeed, the more the audiologist advocates for change, the more the patient advocates for staying the same. The more we push, the more they pull.

For example, if the audiologist says, "Hearing aids will make it easier for you to hear," the patient might say, "I



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hear pretty well most of the time.” If the professional says, “It’s been shown that hearing aids can improve the quality of your life,” the patient might say, “Uncle Fred is 89 years old, deaf, doesn’t want or wear hearing aids, and he’s doing just fine!” We’ve all been there.

Motivational interviewing guides the professional to talk less and ask more questions to encourage the patient to do most of the talking. There is an important caveat: What you don’t talk about *can* hurt you. Nietzsche said, “Silence is poison.” Keep in mind, the goal is not to elicit

### Joan’s Hearing Aid Balance Sheet

Get Hearing Aids	Do Not Get Hearing Aids
More social and family involvement	Continued feeling of isolation
Hearing the bids at bridge games	Not playing bridge
Understanding the grandchildren more easily	Difficulty with soft speech and mumblers
Hearing the TV easily	Playing the TV very loud
Improved ability to use cell and landline phones	Continue to avoid picking up the phone
Finally getting the last word	Continue to argue with son
Cost issues	Keep the money in the bank
Less frustration	Same/worse frustration
Less anxiety	Same/worse anxiety
Less stress	Same/worse stress

just any talk. The professional must try to elicit *change talk* related to problem recognition, expression of concern, intention to change, and degree of self-efficacy. The audiologist's task is to elicit, understand, and effectively manage the patient's ambivalence.

For example, a patient with a mild hearing loss may experience ambivalence that pivots on her desire to hear more clearly combined with her reluctance to wear hearing aids due to cosmetic concerns. Or she may desire the ability to use her cell phone easily, while feeling reluctant to pay for hearing aids (as an aside, patients with mild and moderate degrees of hearing loss often have pronounced levels of ambivalence, whereas patients with severe and profound hearing loss have less ambivalence because their need to "manage" their hearing loss is greater). Thus, the audiologist who appreciates "amplification ambivalence" can respectfully make ambivalence part of the audiologist-patient dialogue, thus voicing (airing) hidden concerns and managing them more effectively, while achieving and maintaining "likability."

Joan is a 68-year-old who recently stunned her adult son by agreeing to an audiology appointment. The audiologist, trained in motivational interviewing, did not rush to be an "agent of change." Rather, he said, "I believe hearing aids will help, but I'm sure you have some concerns, too." He helped Joan fill out a *Hearing Aid Balance Sheet* (see sidebar) to help her acknowledge and amplify (pun intended) her ambivalence regarding pros and cons of wearing hearing aids.

Joan's balance sheet reflects the concerns and thought processes Joan considered and worked through prior to arriving at her decision to try hearing aids. Once the issues were aired and placed "on the table," the audiologist could directly affirm and validate Joan's ambivalence and enter into a frank discussion of the issues important to Joan.

Motivation is not a general trait existing within...an individual...but is an important part of the counselor's task...[which is] not only to dispense advice but to motivate—to increase the likelihood that the client will follow the recommended course of action. From this perspective, it is no longer sensible for a [health-care professional] to blame a client for being unmotivated to change, any more than a salesperson would blame a potential customer for being unmotivated to buy. Motivation is an inherent and central

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part of the professional's task. [Miller and Rollnick, 2002]

## Conclusion

Relationships are multilayered, diverse, and dynamic. There is much more to professional-patient relationships than diagnostics, hardware, and software. The quality of the relationship between the professional and patient impacts whether or not the patient accepts our guidance and recommendations. Successful professionals are able to draw on their personal qualities and skills to achieve a higher level of connectivity and to influence and motivate their patients to achieve an improved quality of life.

Motivational interviewing is a directive, patient-centered counseling style for increasing intrinsic motivation by helping patients explore and resolve ambivalence. Through MI, the patient and the audiologist experience connectivity as the patient becomes an active participant in the discourse, as opposed to the patient serving as a recipient of professional information. The “decision to change” results from this collaborative discourse, which leaves the patient feeling validated, respected, and liked by the professional.

These principles (connectivity, influence, and motivational interviewing) remind us of the 76-year-old woman who joyfully reported to her family that she finally got hearing aids! She had previously visited and frustrated many audiologists. Her daughter asked her, “Why now?” She replied, “He was the first person that asked me ‘How are you doing?’ and, he really, really wanted to hear my answer.” 

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*Acknowledgments:* Special thanks to Thomas Lunner, PhD (Oticon A/S Research Centre Eriksholm, Denmark Docent/Tekn Dr Technical Audiology, Department of Clinical and Experimental Medicine, Linköping University, Sweden; Professor [visiting], Linnaeus Center HEAD, Swedish Institute for Disability Research, Department of Behavioral Sciences and Learning, Linköping University) and Robert Cialdini, PhD (Regents' Professor of Psychology and Marketing, Department of Psychology, Arizona State University), for their kind encouragement and thoughtful reviews and suggestions regarding this manuscript.

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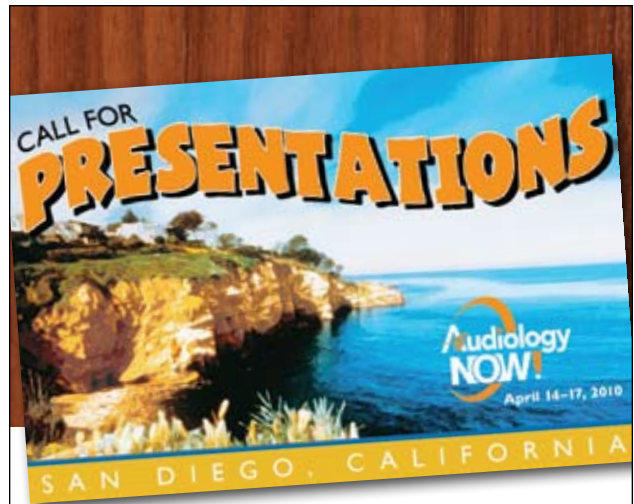
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