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continued

Strategies for managing patients' anxiety and ambivalence about hearing loss: A rationale for Audiology-Psychology collaboration

David Citron, III, Ph.D., Audiologist

Michael Harvey, Ph.D., Psychologist

3

continued

Learning Objectives

- Discuss the importance of responding to patients' affective statements.
- Describe the principles of motivational interviewing, helping skills and L.E.A.P.
- Describe how these tools can be effectively utilized by professionals.

4



Motivational Interviewing (MI): An effective way of talking to people about change.

- Addictions
- Dental Health Practices
- Weight Loss
- Exercise
- Smoking Cessation
- Study Habits
- Treatment Retention
- Diabetes Compliance
- Physical Therapy

5



We face many decisions that require change at every life stage

- Homework
- Career
- Housing (rent, Buy, Sell)
- Marriage
- Children (when and how many)
- Medical decisions
- Retirement
- Live alone vs. A.L.F.
- Accepting help

6

continued

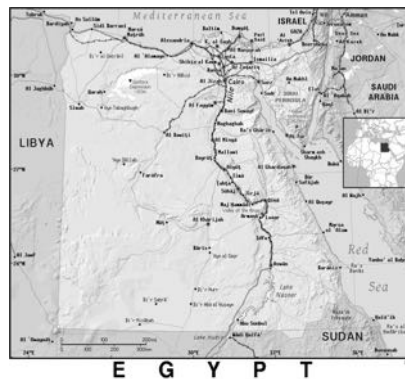
When change is hard, it's often NOT because of:

- Lack of information
- Laziness
- Oppositional Personality ("What ever it is, I'm against it.")

7

continued

Another player is:



8

BUT IS IT???

9

A brief aside

About 50% of people with serious mental illnesses don't believe they are ill and refuse to take prescribed medications. Their main complaint is usually feeling victimized by family, friends, and doctors who pressure them to accept treatment for an illness they don't think they have! It is NOT the person it is the problem.

Source: Amador, X. (2012). I am not sick I don't need help: How to help someone with mental illness accept treatment. Vida Press LLC.

10

continued

A Useful Analogy

Anosognosia: a neurologic disorder that causes poor insight for persons with serious mental illness, including unawareness of one's deficits, symptoms, or signs of illness.

This disorder renders their concepts of self—their beliefs about what they can and cannot do—literally stranded in time. They believe they have all the same abilities that they once had. When one's conception of who one is gets stranded in time, one inevitably ignores or explains away any contradictory evidence.

If brain damage can cause a man to mistake his wife for a hat, it is easy to imagine how it can cause someone to mistake his past self for his current self.

11

continued

Anyone who has dealt with denial by loved ones knows that it can't be fixed simply by educating them about the problem they do not believe they have.

The first step, therefore, is to stop arguing and start listening to your loved ones in a way that leaves them feeling that their point of view—including their delusional ideas and the belief that they are not sick—is being respected.

Source: Amador, X. (2012). I am not sick I don't need help: How to help someone with mental illness accept treatment. Vida Press LLC.

12

continued

Projection-another common behavior with hearing loss

- “I hear fine...people mumble.”
- “It must be the poor quality of the TV speakers.”
- “My teenage grandchildren do not speak distinctly.”
- Etc., etc., etc.
- Understand the “why”...slow progressive nature of hearing loss makes individual unaware/less aware of change...similar to anosognosia.

13

continued

When change is hard, it's most often because of:

- Ambivalence—feeling “stuck”
- Wanting and not wanting change or wanting incompatible things at the same time

14

continued

Because ambivalence is uncomfortable,
it often leads to:

- Anxiety—because we do not like the feeling of anxiety it often leads to PROCRASTINATION.
- Often mistaken by us as resistance.

15

continued

Ambivalence—common in a myriad of
health problems.

- Obesity
- Need for exercise/physical therapy
- Alcohol use
- Diabetes compliance
- Smoking cessation
- Hearing loss

16

continued

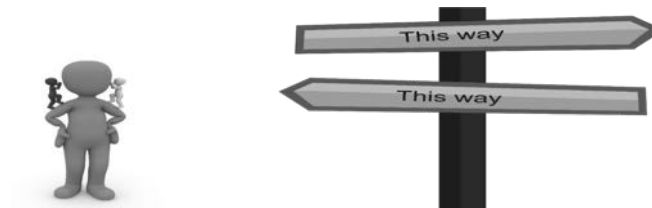


17

continued

What is ambivalence?

Normal process of thinking about the pros and cons of making a change.



18

continued



19

continued

Key factor in hearing loss:

- **AMBIVALENCE!!** Hearing loss is not a priority. We know from research that most patients are aware they have a hearing loss but wait **SEVEN YEARS** to take action!! Hard to make changes!

20

Examples of ambivalent statements:

- “I know I need hearing aids, but I just can’t seem to do it”
- I want to hear better, but my cousin’s new aids whistle all the time and drive her crazy.”
- I want to try hearing aids, but I hate the thought of people noticing them.”
- “The new hearing aid technology looks great, but my sister’s new iPhone aids keep sliding out and she nearly lost one.”

The easy indicator of ambivalence is the **“but”** in the middle. It is as if the internal disputes on either side of the **“but”** cancel each other out so that nothing changes!!

21

Motivational Interviewing:

- Can help resolve ambivalence and help elicit a person’s own motivation to change
- Key is eliciting patient’s own argument to change in a healthy direction.
- Just giving advice will not work!!

22

Motivational Interviewing: Some Basics

- MI is thought of as a “brief” intervention and, indeed, much can be accomplished to move a person toward healthy behavior change in as little as one session.
- It is effectively employed in health care to help patients make changes in their health—obesity management; diabetes management; drug/alcohol addiction; smoking cessation.

23

Spirit of Motivational Interviewing:

- PARTNERSHIP-Work collaboratively and avoid “expert” role.
- ACCEPTANCE-Respect patient’s autonomy, strengths, potential and perspective. Irrevocable right to make decisions about own lives. See world through patient’s perspective. “If I were the patient, how would I feel?”
- COMPASSION-Keep patient’s best interest in mind.
- EVOCATION-Best ideas for change come from patient.

24

continued

How Do We Do This — Use The
Acronym R.U.L.E. — M.I. Is Based On
Other Mental Health Therapeutic
Approaches

- R—Resist the righting reflex.
- U—Understand your patient's motivation.
- L—Listen to your patient.
- E—Empower your patient.

25

continued

Similar to Amador's L.E.A.P. strategy to
manage patients with anosognosia.

- Listen
- Empathize
- Agree
- Partner

26

1. R=RESIST THE RIGHTING REFLEX!

- The righting reflex refers to our tendency to try to “run in and fix” the problem and by doing so, reduce the likelihood of patient change.
- This is natural for us...it is part of our core desire to help others.
- The problem—it does not consider the possibility of ambivalence.
- Patients can be naturally ambivalent—there are times where they feel change is not necessary or possible.
- Reasons—fear; uncertainty; changes to relationships; monetary; time. (Key-LISTEN!!)

27

2. U=UNDERSTAND YOUR PATIENT'S MOTIVATIONS

- We DO NOT motivate the patient.
- Motivation must come from within the patient.
- We find the motivation that lies within the patient and help them to recognize it.
- Key—seek information about goals, aspirations and beliefs...then explore how these relate to their present circumstances.
- Direct them toward the discrepancies between what they want and how their behavior impacts the goals.

28

continued

3. L=LISTEN (“L” IN L.E.A.P.) TO YOUR PATIENT-OBVIOUS, BUT...

- Patients come to us (many times unwillingly) for our expertise.
- MI is geared toward spending just as much time listening as informing.
- They are responsible for bringing about change.
- We must create an atmosphere of “safety and freedom” where they can safely explore conflicts and address realities.
- How?? Be empathetic and communicate that empathy. Look at it from the patient’s eyes. (“E” in L.E.A.P.)
- A good statement: “That makes sense. I can see why you can view it that way.” This involves acceptance/agreement...it is NOT approval though! (“A” in L.E.A.P.).

29

continued

4. E=EMPOWER YOUR PATIENT

- Outcome is best when the patient is engaged.
- All change is ultimately self-change.
- We must support that patient has a “can do” attitude.
- Communicate hope...taking about other patient’s successes can assist.
- Patients will then decide if these ideas fit and how they might use them.

30

SPIRIT OF MOTIVATIONAL INTERVIEWING—WE ACT AS GUIDES!

- Collaboration—Audiologist/patient partnership. We must not offer advice that is restrictive or prescriptive. Understand and channel the patient's aspirations and goals. Create positive environment for change.
- Evocation—Drawing out ideas and solutions from patients. Evoke their reasons for change. We then can guide them by providing information to empower the patient to change.
- Autonomy—Decision making is left to the patient. We cannot argue for change, even when their decisions negatively impact others.

31

Pre-helping skills (Carkhuff 2014):

- Office staff needs to be warm and use affirmations.
- Get a feelings chart—many available on Google.
- Eliminate distractions (cell phone off, etc.)-comfortable seating
- Physical attending-making eye contact, squaring by facing patient fully, leaning forward at least 20 degrees so that our forearms can rest on our thighs. This communicates interest!!
- Observe patient posture, facial expression and body language.
- Suspend judgement.

32

M.I. MICROSKILLS—O.A.R.S.

- O=Open ended questions
- A=Affirmations
- R=Reflective listening
- S=Summaries



33

Sample agenda—express appreciation, your role and time.

“Hello Mr. Smith. Thank you for coming in today. My name is Dr. David Citron. I’m an audiologist. Your doctor has referred you because he thinks I might be of some help. We’ve got about 45 minutes together after we check your hearing and I’d like to use the time to get to know a bit about you. I’m also interested to learn what your expectations might be.

34

Affirmations-anything positive that is noticed about the patient:

- Awards
- Attempts
- Achievements
- Accomplishments
- Prior successes

35

Providing Affirmations-builds a sense of self-confidence:

- “Thank you for coming in today.”
- Thank you so much for choosing us as your audiologist.”
- “You seem like a person who can accomplish what you set your mind to.”
- “You’ve demonstrated commitment to your health just by coming in today.”
- “You feel confident that you could do it if it were important to you.”
- “I saw on your history form that you are a veteran. Thank you for your service.”

36

Barriers to Engaging

- Asking too many questions—best to have history form completed in advance.
- Coming across as being too much of an expert-offering advice or solutions prematurely.
- Labeling your patient as “hearing impaired” or similar terms creates a barrier to the relationship.
- Assigning blame for the problem the patient brings into the session.
- Idle chatter---ice breakers are OK

87

Examples of inviting open questions (invites patient to talk about what is on their mind.)

- “What brings you in today?”
- “What’s on your mind?”
- “What would you like to talk about today?”
- “How can I be of service to you?”
- “How would you like to begin?”

88

Closed-ended questions vs. open-ended questions:

- Are obviously important (medications, family history, imbalance, tinnitus, etc.).
- One-word/very short answers can slow down the process and make it much harder for you to keep the session momentum going.
- Best idea—mix the open and closed-ended questions and construct a much higher proportion of open-ended questions.
- Practice, practice, practice!!

39

Good follow-up open-ended questions:

- “What do you already know about hearing aids?”
- “What listening situations are most challenging? Why?”
- “What kinds of things do you do now for relaxation?”
- “What are your hobbies/favorite activities?”
- “Describe for me your typical day/week.”
- “How has your hearing loss affected your life?”

40

continued

Open ended questions:

- Leave plenty of room for your patient to talk about what is on his or her mind,
- Put the responsibility for moving the conversation along on your patient's shoulders rather than on yours.
- Answers to open questions also often reveal details of a problem or direction to go that you might not have thought about.
- Keep the session momentum going.

41

continued

Reflective listening-most important skill
in motivational interviewing!!

Understanding what the patient is THINKING
and FEELING and saying it back to the
patient.

"If I were the patient, how would I feel??"

Charts-can develop a feeling vocabulary!!

42

IT'S NOT ABOUT THE NAIL:

The message is “Do not try to fix it!! Respond to her feelings!!”

<https://youtu.be/-4EDhdAHrOg>

43

What are our strengths and what's missing?

- We are great at content-based counseling.
- We excel at dealing with the technical aspects of care that is information-based (Explaining outer hair cell damage; use of telecoils; wireless streaming; causes of tinnitus).
- Our mistake: we see ourselves as just supplying cognitive information—hard cold facts and descriptions—being “Dr. Informative.” Audiology’s version of Dragnet.
- We are not comfortable managing affect or feeling statements.

44

Why is affect so important?

- Feelings are the major factor that makes patients connected to us. “He/she knew how I felt.”
- With any health care provider, patients respond positively to having their feelings acknowledged and validated.
- It is the most critical skill in clinical care because it reflects the patient’s affective experience in relation to their worlds.
- Patients are looking for the meaning behind the information-- more than just the facts.

45

Organizing the patient’s thoughts—use the 5Ws(Carkhuff 2014):

- WHO and WHAT was involved?
- WHAT did they do?
- WHY and HOW did they do it?
- WHEN and WHERE did they do it?

46

continued

Beware the question/answer trap!! Shift into “R” — Reflections:

- Can be “mixed” with questions!!
- Statements made to the patient that mirror, give back, repeat, rephrase, paraphrase, or otherwise make manifest what you hear the patient saying or see the patient doing, such as smiling or looking sad, for example.
- Reflections are really guesses or hypotheses about what is going on in the patient’s mind and heart, so you are reflecting what you think the patient means by what he or she says and what you think your patient feels emotionally as well.
- Delivered confidently as statements with your voice inflection going down rather than up at the end. And they stand alone and don’t need to be followed by a question.
- Start basic at beginning of session and morph into more complex reflections. Paraphrasing, double-sided reflections, using metaphors, and reflecting feelings, are typically used later.

47

continued

Reflections-what patients are thinking and feeling:

Patient: “I’m not sure why I’m here. My doctor just told me to come.”

Reflection: “You’re not sure why your doctor referred you to me.”

Patient: “I’ve been concerned about my dizziness for awhile. I don’t think it’s that bad, but I fall sometimes.

Reflection: “You’re worried about your dizziness because you fall occasionally.”

48

continued

Stems—can help start reflective statements:

- It sounds like....
- That makes me think...
- If I understand you correctly...
- What I am hearing....

49

continued

Hearing loss samples:

Patient: "I don't think I have a hearing loss."

Response: "It sounds like you are not sure about your diagnosis of hearing loss."

Patient: "I don't like my wife's frustration of having the TV up."

Response: "What I am hearing is that having the TV volume up and your wife's frustration are things you'd like to change."

50

continued

Reflective statements:

Used for empathy and understanding and a way for us to see things through the patient's eyes. Most often praised by patients: "The audiologist was tuned in and really listening to me."

Could lead the former statement (TV loud) into a C.O.S.I. goal!!

61

continued

Hearing loss sample responses to feeling and meaning

Patient: "I'm tired of having my wife nagging me about my hearing."

Response: "You feel frustrated with your wife's nagging."

Patient: "I miss hearing the sermons at church."

Response: "You feel sad because you cannot hear the sermons at church." (Meaning by personalizing problem).

Patient: "I really like going to Rotary every week, but have a lot of trouble understanding the program speaker."

Response: "You feel upset because you cannot hear at Rotary and you want to stay active." Personalizing goals—leads to change!

62

continued

Don't argue, USE EMPATHY. Ally with where they at! The "E" in LEAP

- "It's difficult for you to think of changing your eating habits because you are surrounded by people who don't eat the way you do."
- Hearing example #1: "It's difficult for you to think of getting hearing aids because you are around people who have theirs in the drawer."
- Hearing example #2: "It's difficult for you to think of getting hearing aids because: they show too much; whistle too much; amplify too much...etc."

83

continued

Using patient statements to tailor a response strategy—FOLLOWING style

- Good for a patient in a highly emotional state.
- Listening is the dominating factor.
- No directing, instructing, agreeing or disagreeing, warning or analyzing.
- "Follow" the patient's lead with a reflective response.
- Seeing and understanding the world through the patient's eyes.

Best employed with a parent in tears having just learned their child has a severe hearing loss or a high priority tinnitus patient with extreme anxiety.

84

GUIDING style—crux of M.I.

- Similar to a tour guide who has no power to decide what to see or do but helps you find your way and get there.
- In managing behavior change, the guiding style says “I can solve this for yourself.”
- Best described as “encourage,” “motivate,” “support,” and “elicit.” Most common us as audiologists.
- Examples: (Listening) “You are feeling concerned about your hearing and you are not sure where to go from here.” (Asking): “What kind of change makes sense to you?” (Informing): “New technology HAs would make sense, but how does that feel for you?”

A good guide uses a mix of listening, asking and informing interchangeably with a use of reflective attending.

85

DIRECTING Style-practitioner Takes Charge

- Director tells patient what to do with the thought that he/she has the expertise and power to do so.
- Can lead to pushback-”beware the righting reflex.” It is often overused due to changes in health care that are action oriented and coupled with there is a rush to check off boxes, reduce costs and conduct standardized “cookie cutter” assessments.
- Can be necessary to save lives (Story).

Most problems are solved using a mixture and balance of following, guiding and directing. Typically better to employ a combination where you follow and consider a bit of support and guide before shifting to a directing style.

86

continued

Summaries:

A long reflection of more than one patient statement.
Uses opportunity for practitioner to guide behavior
change by selectively summarizing reasons for change.

67

continued

Sample Summary-Ambivalence

"I don't want to move. I like my home. I would have to change
MDs and that would be a hassle. I am worried about falling
because I feel unsteady on my feet. But if I move, I could move
closer to my grandchildren and see them more often. I might
feel safer in senior housing."

68

continued

Summary response to patient:

"If I understand you correctly, you've been thinking about moving into senior housing. The downside is that you would have to find new doctors and it would be unfamiliar. Thinking you'd be safer in senior housing and closer to the grandkids."

59

continued

Sample Summary-Hearing Loss

"My wife complains I cannot understand her. My daughter too. I have to turn the TV way up. I hear the boys at the lodge just fine. I am thinking I may need a hearing aid, but most of my buddies keep them in the drawer. My cousin's aids whistle all the time, pop out of his ears and drive him nuts. I do want to understand my grandchildren when they visit."

60

continued

Sample response to patient:

“If I understand you correctly, you’ve been thinking about getting hearing aids because you have trouble understanding your wife and daughters. The downside is that your friends and family have had problems with hearing aids. Thinking you’d be happier using hearing aids so understanding your grandchildren and enjoying television can happen.”

61

continued

There are Four Processes in Motivational Interviewing:

- Engaging
- Focusing
- Evoking
- Planning

62

1) ENGAGING

Process of establishing a trusting and mutually respectful relationship. Need connection prior to change.

- Attuning
- Aligning
- Joining with
- Helping Relationship
- Connecting

63

Dis-engaging—what NOT to do:

- Assessing—Do NOT ask a bunch of questions-especially closed ended-will stall relationship.
- Telling—Resist the Righting Reflex!!
- Power Differential—Do NOT come across as a big expert/authority figure.
- Labeling—“Whiner” “Stubborn” “Oppositional” “Know it all”—Suspend judgement!!

64

continued

ENGAGING INVOLVES:

Feeling welcome-use an affirmation

Feeling comfortable

Feeling understood

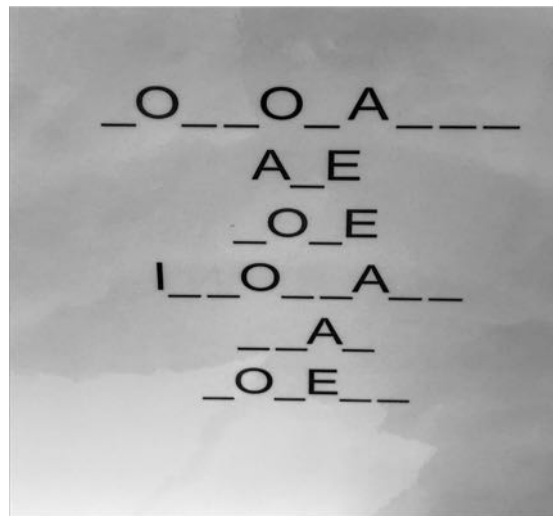
Exceeding expectations

Having mutual goals

HOW?? FEELING UNDERSTOOD—REFLECTIONS ARE THE
CORE OF MI!!

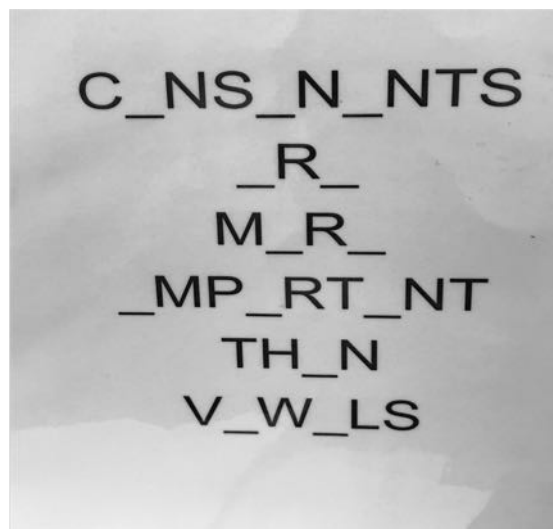
65

continued



66

continued



67

continued

2) FOCUSING-Ongoing process of seeking and maintaining direction

Setting an agenda

Patient goals and priorities

Audiologist goals and priorities

Can differ—i.e. audio vs audio/HA consult

Create clear direction for change plan

HOW?? Use O.A.R.S. and listen carefully!!

68

continued

3) EVOKING-Eliciting a patient's own motivation to change

KEY- Eliciting "change talk." Something in the patient's speech that favors movement in the direction of change.

"I can"

"I want"

"The reasons are"

"I will"

"It will solve problems"

"I wish"

KEY—Get it; reinforce it; encourage it; The more they talk about it, the more likely it is to change behavior.

69

continued

Moving toward change—D.A.R.N.

- **Desire** is the first theme of change talk. It includes verbs such as "want," "like," and "wish."
- Sample statements are: "I like the idea of having easier listening on TV." "I wish I could understand my grandchildren when they call from Fargo." "I want to enjoy the sermons at church."
- These type of statements reveal either desire for change or to maintain status quo.

Be on the lookout for the "but" or similar clue of ambivalence!

70

continued

Moving toward change—D.A.R.N.

- **Ability** tells us what the patient recognizes as being within his/her ability. Key verbs here are “can” as well as the conditional “could.”
- Sample statements are: “I *could* try walking by the river as a relaxing activity for my tinnitus.” “I *can* see myself trying hearing aids.” “I might be *able* to try hearing aids when I have court cases.”

71

continued

Moving toward change—D.A.R.N.

- **Reason** can also be expressed for change. No real verbs, but it can be combined with the **desire** statements.
- Some examples: “My hearing loss keeps me from going to Book Club meetings.” “Trying hearing aids would help me hear in church.” “I want to hear my grandchildren as they grow up.”

72

Moving toward change—D.A.R.N.

- **Need** involves imperative verbs such as “must,” “should,” “ought to,” “need,” “have to” and “got to.”
- Samples: “I need to communicate during my bridge games.” “I ought to get hearing aids so I can hear my golf partners.” “I must keep going to my Rotary meetings.”

Be wary of any ambivalence that can intrude into any of the above-mentioned themes. Almost always, this can easily be recognized by the “but” that can show up during change talk statements.

73

What’s missing from D.A.R.N.?

- **Commitment** is the 5th form of change talk. The key verb is **will**. To say “I can” is not the same as “I will.” To say “I want to” is not the same as “I intend to.” What is missing is agreeing to change as opposed to just expressing reasons to do so.
- Key strong statements include: “I will,” “I intend to,” “I am ready to,” and “I promise.”

It is critical NOT to miss lower levels of commitment such as “I plan to,” “I hope to,” “I’ll consider it,” or “I will try to.” These can signal some doubt about the ability to change. Careful use of listening, reflection and guiding are keys to reinforcing change.

74

Sample questions to generate Change Talk:

- “Why do you want to make a change?”
- “What are the reasons for change?”
- “What would some of the benefits be?”
- “How might you go about making a change if you wanted to be successful?”
- “What would be your first step be?”
- “What options do you see yourself having?”

75

4) PLANNING-Develop specific plan that patient agrees to and is willing to implement. This is the “P” (Partner) in L.E.A.P.

- Smart
- Specific
- Measurable
- Achievable
- Timed
- Meet Goals

76

continued

PRACTICE, PRACTICE, PRACTICE!!

You can always try it on your spouse, friend or son/daughter

77

continued

QUESTIONS??

78

continued



Photo by David Citron, IIII

79

continued

SCENARIO ONE:

66 year old male, bilateral moderately-severe SNHL. Worked construction for 45 years. Nasty and antagonistic. "I don't have a problem hearing and I wouldn't wear your damn hearing aids even if I did!" BTW – his wife insisted on coming to the evaluation/consultation...they argue a bit about whether he does or does not need hearing aids, wife turns to audiologist and says "What do you think?"

80

continued

HOW DO YOU RESPOND?

- A. "Hearing aids are so much better now. Smaller, great sound quality, and much better in noise. I have some here so you can listen and hear the difference. Let's try them."
- B. "You are not sure about your diagnosis of hearing loss and do not want hearing aids even if you were sure about it."
- C. "You feel frustrated because you argue with your wife a lot about your hearing, and feel pushed to be here today."
- D. "It's OK that you feel that way. Hearing loss is very slow and gradual so that most folks are unaware it's changing. We have a 60-day no-obligation trial period. Let's arrange for that."
- E. Statements B and C.

81

continued

SCENARIO TWO:

16 year old girl, junior year of high school. Bilateral Mod SNHL. Has worn HAs since age 5 years. Since HS wears them less and less, trying to be more socially accepted. Her grades have gone down as she decreased the time she wears hearing aids at school. She tells the audiologist "I don't wanna look like a freak."

82

continued

HOW DO YOU RESPOND?

- A. "You are wearing your hearing aids less and less at school because you want to feel accepted by your peers."
- B. "Your grades have really suffered. The newer hearing aids are much smaller and much less visible than your present ones. Let me show you what they look like."
- C. "You feel frustrated because wearing the hearing aids makes you seem like a freak and you want to be a part of your group of friends."
- D. A and C
- E. All of the above.

83

continued

SCENARIO THREE:

45 year old female trial attorney. Mild-Moderate SNHL. Does not like to wear hearing aids in court. She is convinced as the jury becomes aware of her hearing aids, her stature is compromised. She says to the audiologist "I know I need hearing aids, but I absolutely will not wear them in court."

84

continued

HOW DO YOU RESPOND?

- A. "What are your challenges with your hearing loss in court?"
- B. "You are fearful that the hearing aids will cause negative bias by the jury during court and impact the verdict."
- C. "You feel that wearing hearing aids in court is an emotionally traumatic experience. How do you feel about use in non-courtroom situations?"
- D. "You are aware of your hearing loss, and know you need hearing aids, but do not want to wear them in court."
- E. All of the above.

85

continued

SCENARIO FOUR:

24 year old male just completed 4 years in the military as weapons specialist. Primary complaint = constant tinnitus both ears. Pt has hearing loss consistent with mild-to-moderate SNHL from noise exposure. Is dating new girlfriend and wants to get married, he feels flawed and embarrassed and he worries she will say no to his proposal.

86

continued

HOW DO YOU RESPOND?

- A. "Thank you for your service and for coming in. Your constant tinnitus must be very frustrating for you. Tell me more."
- B. "You do not want your hearing loss and tinnitus to cause any embarrassment. Can we discuss a treatment plan?"
- C. "You are worried that your hearing loss will make you look impaired and embarrassed in your girlfriend's eyes and affect your marriage proposal."
- D. A and C.
- E. All of the above.

87

continued

THANK YOU!!

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88