Therapeutic Techniques to Build Alliance with Complex Patients and Their Families

Recorded Apr 29, 2020

Presenter: Michael Hoffman, PhD
AudiologyOnline.com Course #35055

- [Christie] At this time, it is my pleasure to introduce Dr. Michael Hoffman, who is currently the pediatric psychologist at Nemours Hospital for Children with a specialization in working with children with hearing loss. Doctor Hoffman completed his PhD through the University of Miami Clinical Psychology Program and his pediatric psychology residency and fellowship through Nemours. His research and clinical work has centered on integrating psychological services into audiology and ENT clinics and improving quality of life in children and adolescents with hearing loss. Welcome back, Dr. Hoffman and I'll hand the mic back over to you.

- I'm really excited to be here and to talk to you today. I'm going to be discussing therapeutic strategies or techniques, to build alliance with complex patients and their families. This is an issue that I'm really excited to talk about, one that's definitely near and dear to me. My hope is, over the next hour or so, to turn you all into junior psychologists, basically. We're gonna talk about a lot of different techniques and strategies that I've been trying to use and figure out how we might be able to apply them in your context. Disclosures, I have none. So just an overview of the format for today. So I will introduce myself, a little bit more and my background. We're gonna talk about general skills that can be used for really any patient that comes into your room. The importance in considering diversity within healthcare, as that really ties more into thinking about the entire person, that is their, and the entire person that is present in the room and their family. Engaging patients in behavior change. I have that listed, because ultimately, when we are talking about helping complex families, or working with complex families, we're really discussing this idea of behavior change. How do I get this family or this patient to engage in a different pattern of behavior than they are doing currently? Just a major component that's gonna underlie what we do. Then we'll have some role play or some case examples to try and bring it to life and some time for questions at the end. But as Christie mentioned, if you have any questions throughout, please feel free to ask. Please feel free to turn them out. I would much rather be more specific to your questions, than just using the pre-determined material. For the outcomes, so I am going to present specific strategies for improving communication with patients. My biggest pet peeve with presentations is when they talk about lots of wonderful things in theory and you are vigorously nodding your head throughout the presentation and then you walk out of the room and you're kind of like, "Okay, so how do I actually apply this "to my day-to-day, my job?" So I really wanted to feel concrete and applicable. We're gonna discuss multi-cultural factors, as that relates to patient and provider experience. We're gonna go through some case examples. Okay, so just a little bit about me. So I am, as Christie mentioned, I did my PhD in Clinical Psychology at the University of Miami. My specialization is in Pediatric Psychology. What that means is that the vast majority of my training has been done in hospital setting, with pediatric patients. Not only specific to hearing loss, but other things, such as in-patient consultations, cranial facial patients, cardiac admissions, diabetes, cancer, pretty much any pediatric medical illness. After that, I did my residency and my fellowship at Nemours/AI duPont Hosipital for Children, which is in Wilmington, Delaware. During that time, I really started to emphasize a focus on working with kids who were deaf and hard of hearing. Within our audiology ENT clinics and the cleft palate cranial facial clinic.

Currently, I am still in that role at Nemours. My specialization is cranial facial cleft palate, audiology and ENT and working on integrating psychology services into our clinics for all of our families. I also am a person with hearing loss myself. I was born with severe to profound hearing loss, Connexin 26. I was diagnosed at four months of age. I was bilaterally implanted at five months, bilaterally aided, I'm sorry, at five months of age. So I wore hearing aids for the vast majority of my life and then I was implanted on my right side, at 28. So I share that information because, in creating this presentation, I'm not only drawing on my professional experience and my professional training, but also, over 30 years of experience as a patient, in the healthcare system. That includes being in large hospital settings, university training clinics, small private practice, so I've had the opportunity as a patient to experience a lot of different settings, within audiology. So, without further adieu, we will jump in and talk a little bit about general skills that can be used with all patients. So the very first thing I wanted to talk about was normalizing. To take a second and pause and think about how often do you purposefully normalize information that your patients are giving you? I ask this because, normalizing is really one of the most powerful tools, that I as a psychologist use. I will say, I at least aim to normalize minimum four to five times in the course of a session, that might be 45 minutes. When you have a patient who is coming into your room for say an audiology visit or a checkup, they're often thinking about these issues that are sometimes feel very unique or specific to them. They don't interact with a lot of other people who have hearing loss, typically. So it's kind of a weird, squishy topic to talk about. So, sometimes patients may be feeling kind of anxious, or uncomfortable in discussing their experiences. If any of you have ever gone to any sort of medical specialist for your own health, think about that feeling of walking into the waiting room, waiting to meet the doctor. You're like kind of nervous, a little like wondering what they're gonna say. You don't know what the course of treatment is gonna be and so it's sort of a little bit of an anxiety-inducing process.

So, in those moments, using normalization can be really, really helpful. What you are going to do is, communicate to your patient, that the things that they are experiencing are really not uncommon for them. So this is a little above and beyond just saying, "Oh yeah, that's totally normal, I hear that." I'll often use phrases like, a lot of children will say that, the lunchroom is hard for them to hear in. Many others frequently tell me that, using an FM system, is super annoying. Then I'll say things like, "Given your level of "hearing loss, I would expect that "that would be a challenge for you. "So for example, yeah, when you go out "with your family to dinner and you're in "a noisy restaurant, I would certainly expect "that it would be hard for you. "A lot of patients tell me this." Or, "This is very common among others with hearing loss." So I would challenge you, as providers, to really think about, "How often do I make "an effortful, purposeful point, "to normalize with my patients? "To communicate to them that, "Hey, these things you're experiencing "are actually quite common and thank you "for sharing them with me and thank you "for opening up the door for us to have a conversation." One of my favorite ones to do with younger kids, or teenagers, 'cause they often don't like to talk about themselves, or they'll kind of give you the shoulder shrug and say, "I don't know." Is, I'll say things like, "You know, is it okay "if I tell you about what I hear from a lot of other kids? "Then you can tell me if those things apply to you." They will often say, "Yeah, sure." Then that'll facilitate dialogue. So really think about how often are you purposefully and effortfully normalizing some of what your patients are sharing with you, to make them feel comfortable and to build alliance in the room. The next item, the next kind of strategy that I would talk about is, reflective language. This is thinking all about, "How am I communicating to my patients or my families, "that I am actively listening and paying attention to them "and I am hearing what they are saying?" I have seen many times, with audiologists I've worked with in the past and even for myself. I'm thinking about the schedule I have for the day. I've got eight back-to-back-to-back patients. I'm tired, I wanna eat lunch. My baby kept me up last night and I've got this whole protocol that I've gotta get through, that our boss just tweaked or adjusted. So you have this whole list of things that we need to do.

So sometimes, it's really easy for us as providers, to not focus and not be present in the room. So engaging in some form of reflective language, is going to show your patients that you are actively listening to them and hearing the information that they are sharing with you. So, some examples here. How do you show your patients you're listening to them? "If I am understanding you correctly..." "It sounds like..." "What I'm hearing is..." "I get the sense that..." "It feels as though..." Every one of these is a way for me to reflect back to the patient, the information that they gave me. Psychology 101 is, you should be asking as few questions as you can and offering as many reflections as possible. Think about for yourselves, any time that you have gone maybe home, to visit your family, or out with a friend. They're just peppering you with questions, right? "What about this? "What about this? "What about this? "What about that? "How is your mom, how is your dad? "How is your son? "How's school, how's work? "Are you dating anyone yet?" We just get bombarded with questions and we really don't like that. So if you have patients who are particularly complex, coming into your room and we are just throwing a bunch of questions at them, they might start to clam up a little bit. Reflective language is a way to get more information, without asking questions.

So for example, "If I am understanding you correctly, "what you're telling me is, you hate using your FM system. "It's just really frustrating, "because you have to carry it from classroom to classroom." Or, "When you're in a business meeting at work, "it's really difficult to understand the sounds "that are going on around you and you feel like "the FM system's not working." Those are reflective statements, that are going to elicit more information back. One of two things are gonna happen. Your patient is either gonna say, "Yeah, you nailed it. "You got it", and they're gonna be happy, 'cause they're gonna feel like they're being heard. "You totally understood what I just told you "and you are listening." Or if we are off base, if I say, "It sounds like the lunch room is really hard." And I'm off base, what that patient is going to do is, correct me. They're gonna offer corrective feedback and corrective information, to tell me what I need to know. Either way, I am going to feel confident, that I am on the right path, in terms of understanding the information they are presenting to me. Or, I'm gonna get corrective feedback and get to the right path. In the process of doing that, making them feel like they're heard and understood. It's a very simple, very easy technique, but it would elicit a lot more information from you, in more of an open ended way. Think about when we ask questions. We often use them in an upturn. "What do you want for dinner?" So there are ways to take those questions and change them into a downturn. "I'm thinking about dinner." Or, "What do you wanna do with the FM system? "Do you wanna keep using it?" Or, "So the FM system is a challenge for you, huh?" There are ways to use that reflective language and to build on that and get more information from them.

So now, we are going to come to what I think is my absolute favorite point, from this presentation. If you remember nothing else about what we discussed today, I want you to take home this part and that is, you should hear me in your head saying, "Avoid being the finger-wagger." So let's back up for a second, before I kind of dive into the context of this slide. I want you to take a moment and again, think about going into see a doctor. We'll call it your primary care physician. Think about that experience of going into the waiting room and you know you're going in for you annual physical and you are waiting for the moment when your doctor's gonna tell you, "You really need to lose about 15 to 20 pounds." Or, "You need to stop smoking." In those moments when we get that information from our doctor, how many of you are ever like, "Oh me, I need to lose weight?" Or, "I should stop smoking? "I had no idea." So, we get these, we are waiting for these things. We are waiting for our doctors or our medical providers, to tell us what is "the gold standard", or the appropriate level of care that we should be engaging in. So, in those moments, how many of you walk out of your doctor's office and you're like, "Yeah, I'm definitely gonna lose "15 to 20 pounds. "I'm getting on it right now, "I'm gonna go start a diet. "I'm gonna clean out my fridge. "No more alcohol." Or say, "I'm gonna go throw out my cigarettes in the trash. "Right now, I'm never smoking again." It doesn't work. Simply having your doctor tell you, "Hey you need to engage in this behavior change, "because it's not good for you." Is not effective. It does not drive motivation or change in people.

So, knowing that and thinking about that, let's jump back into what often happens with our patients. I'm going to take the example of someone who doesn't like to wear their hearing aids at all. Let's say they are a young adult, they're in college. Maybe they've been struggling with their grades a little bit. They would probably benefit from using their devices, but they just don't. In today's day and age, we'll say they still live with their parents. Their parents are bringing them in, for their visit. What are the chances that that child knows they are going to be told that they need to wear their hearing aids more often. 100%, they absolutely know that information is going to come. We as providers, our gut instinct, what we've spent years training on, are these gold standards. "This is what you're supposed to do. "You gotta wear your hearing aids all the time. "You should be using the FM system. "If you don't, you're missing all these opportunities "for learning or conversation." We as providers, often lean into this idea that we have to just provide the education and if I provide the education, the family should just do what I say. I'm the one who went to grad school. I'm the one who spent years working in these clinics. I'm the one who studied this forever. Why don't they just listen to what I say? Flip back to kind of what we said about our personal experience. Just getting that information, does not work. It is not going to engage them in behavior change. When we sit there and we kind of do that finger-wagging and say, "You should be wearing your hearing aids. "You should be losing weight. "You should stop smoking." What we're doing is, "You should do what I'm telling you to do, "why don't you do it?" This is not going to invoke behavior change, even though that's what we're hoping will happen. Extensive research has shown that education in and of itself, is not sufficient to produce behavior change. I'm gonna say that again, because I think that's the take home, one of the most important points of this presentation. Again, education in and of itself, is not sufficient enough to produce behavior change. It just does not work. Think of your own experiences when you're told what you need to do from a medical standpoint, doesn't usually motivate us very much. Think about some of the families that you've had.

Take a moment, pause, reflect back on some of your more complex or challenging families, when you've walked out of the room and you're like, "Whew, that was brutal." See if you can queue someone up in memory. So, when we are being lectured, most likely, when we are being told what to do, when we are experiencing the finger-wagging, that patient, or their family, is going to become defensive. They may feel closed off. They may justify or explain their current views. They're gonna feel misunderstood. So, let's go back to the personal example of losing weight. Well you know, you try having three or four kids "and working a full time job and trying to cook for all of the meals for everyone, every day. "You know, it's not that easy. "I can't just go to the gym whenever I want." Or, "Ugh, they don't understand "where I'm coming from anyways." Or, "You know, this is why I do what I do. "This is why I'm ordering McDonald's. "I don't have time from picking up the kids in school, "and going to work." Again, it is the same thing for us, as providers, with our patients. When we get into that finger-wagging mode, when we are telling them what the gold standard of care is, we are actually lecturing them in a way that is gonna make them become defensive, become closed off and not want to engage. "Yeah, I know I'm supposed to wear my hearing aid "all the time. "I know it would probably be helpful in class. "I don't want to and this audiologist just telling me "that I need to wear my hearing aid, "is like, whatever. "Like, let me just get what I need to get. "Get mom and dad off my back and get home." If I asked you how many of you have experienced that type of reaction before, I'm assuming every single one of you, would be raising your hand. I still experience it myself, at least once a day. So what do we do with that? In sum, what we are experiencing is, resistance. We are getting resistance from the patient to engage. If you find yourself experiencing that resistance, there are ways to kind of back up. So, the number one thing you should be thinking to yourself, "If I am experiencing resistance." If you catch yourself saying, "I'm going down that road again. "I'm telling them what to do "and they clearly don't seem interested. "There's no way this kid is gonna possibly "put in their hearing aids." Or, "There's no way this patient "is gonna wanna engage with me."

Pause for a second. How many of you have ever stopped and said, "Hey, I can see that you and I right now, "are not really on the same page. "I can see you're kind of shutting down a little bit. "Do you mind telling me a little bit more about "kind of what's going through your head?" Gather more information. If you find yourself doing all of the talking and telling them what they should be doing, stop, call it out, ask them, "What's going through your head? "What are you thinking?" The second that they give me something, "You know, I just find it such a pain "to change the batteries and manage the batteries. "Sometimes I'm really worried about losing my hearing aids, "if I carry them in between from class to class "and I don't want my parents to yell at me "when, if I lose them. "So it's just easier not to wear them that much "and I leave them in my dorm room." The second they give you that information, I would turn around and say, "Thank you so much for sharing that with me. "I really appreciate you letting me know." I'm going to encourage them and praise them for doing that. Receive it almost like a gift. Then I'm gonna shift my thinking and say, "I know that them hitting this gold standard "that we want, is likely not going to happen." There's no way walking out of this room, this kid is going to wear her hearing aids, 24/7 in every class that she has in college. So, thinking about, well is there a compromise that can be had? What middle ground could we find? How many of you have ever paused and said, "All right, I just tried to give them "the clear standard of care. "They're obviously not going to hit that. " I don't know what to do." So you know what, let's come up with a compromise. Let's see if we can find a middle ground. I think a lot of times what happens is, our brain jumps back to that point of, "I've got all these other patients "I've gotta get through. "I've got a whole protocol in testing I gotta do. "So like let me just move on to the next person "and I'll see them again in six months "and hopefully something changes." Pausing, stop. Call out the resistant. Get some more information and figure out if there's a middle ground that can be had. Maybe there are a few classes that the child would feel comfortable wearing their hearing aids in. Maybe there is a way that we can problem solve not losing them, to make her feel more comfortable. Maybe we can elicit a discussion between the child and her family about what is going on. All right, quick water break, sorry.

All right so here's also another trick that I really like, that I use quite a bit and you may have heard me refer to this, in some of my language already. How to provide information. I am not saying that we should never give information about the standard of care, or what the best practices are. We absolutely have to do that. I am just encouraging you to be mindful and think about, "If I am going to give them "this education, I wanna make sure that I'm also "helping them navigate whatever challenges are coming up." So, asking permission. When we provide information, I love to get permission to increase buy-in. "Is it okay if I tell you a little bit about "some strategies that might be effective for you?" One of two things are gonna happen. They're either gonna say, "Yes", or they're gonna say, "No." If they say, "Yes", then they're pretty much obligated to listen to you. "I just gave you permission to give me more information "about what might be helpful. "So it's gonna look pretty rude on my behalf, "if I said, "Yes" and I just totally zone out." So the second someone grants you permission, to give them more information, they're going to be more likely to receive that information. If they say, "No", which I will tell you, in my experience, is actually fairly rare. They are clearly not in a place where they were ready to receive that information anyways. They were not going to engage in any sort of behavior change. If a patient is already at the point where they're just saying, "I really don't even wanna hear it", then you are better off preserving that alliance with your patient, saying, "You know what? "Okay, I appreciate your honesty. "Let's touch base next time and talk about more strategies." Then pushing in that moment, because you will already be fighting a losing, uphill battle. But I can promise you, the number of times that people say, "No", is actually quite low. And, when we ask permission, what we're doing is making people feel like they are in control of their own visit. They are not there just getting dictated to, or talked to by us, as the expert and them as the people who have to receive their information. We are acknowledging that patient as an expert in their own life, in their own experiences and working in tandem with them to figure out how we can best come up with a solution, or give them information and help them move forward.

Go back to that reflective listening slide and you think about some of the statements. "What I'm hearing is..." "What it sounds like..." "If I'm understanding you correctly..." All of those phrasings, are designed in a way, to help that patient feel like they are in control and that they are valued and they have important information to contribute in their visit. So, hopefully as you're thinking about these things, it's kind of stirring and getting you thinking about some of those complex families or patients you've dealt with and wondering how you might be able to change those interactions. I'm gonna repeat it one more time. We don't wanna be the finger-wagger. The education in and of itself, does not work. So we're gonna get into more examples of how to get around that and kind of motivate them a little bit. But know that, simply providing information, is not going to change. And a reminder, we're not just treating the ears. It is super easy to get caught up in all of the things that we have to do over the course of our day and all the patients we have to get through, all the notes we have to write, all the billing stuff we have to do, all of the documentation we have to submit for molds and such. But pausing and recognizing that you need to be present with your patient, and then treating them and acknowledging them as a whole person and not just a set of ears that we are triaging, when they come in the room. Ah, here's an example of this for adults, that I really like to present. I cannot claim responsibility for this. This comes from a study in 2017, from Abrams, but I thought this chart was a perfect example of highlighting how hearing loss impacts the entire person and cover the whole spectrum. Someone who experiences hearing loss, then will experience some sort of compromised speech perception, which is going to require a greater communication effort, reduced social engagement, impaired cognition, poor physical functioning, poor quality of life. So something starting from the ears, can really have this incompetent, long, caring effect across the entire life span. All right, so we have a question. "So how might an audiologist help a patient "who comes in for a hearing aid consultation "who insists on determining their own method of fitting?" But you know, clinically, it is very inappropriate. You might try and gain information on why they feel this way is best for them, and you slowly try to transition them to a more suitable path. Yeah, okay. So I'm gonna hold off on that, that's a really good question. We're gonna come back to that one, towards the end. Because we're gonna walk through that a little bit more. But thank you for submitting that.

So, multi-cultural identity. This is a really, really important piece to me and I think it's something we should be thinking about all of the time. So here, this is a slide that has kind of different areas of multi-cultural identity, that we should be thinking about and reflecting on. Race and ethnicity, age, religion, SES, education status, sexual orientation, financial standing, citizenship status. So there are lots of different factors that come into play, into the room. I walk into the room, I am a white, hopefully somewhat young, well educated male. Who is able-bodied, aside from my hearing loss. So there's a lot of privileges that I benefit from. I may be serving a family that is a person of color, maybe they've got some sort of complex medical diagnoses going on, Maybe they are a family that doesn't have legal documentation status in the United

States, maybe they are on some sort of Medicaid or welfare, all of these other things are coming into factors in the room. I don't know how often we really pause and think about the role of multi-cultural identity, with our patients. If you are experiencing some sort of resistance, I would encourage you to think about this component. What multi-cultural factors might be playing a role in the room? So I am going to for instance, draw on the clinics that I've worked with. The vast majority of the audiologists that I've engaged with are female and they are white. That does not match up with the vast majority of patients that we see. In Miami, a large percentage of our patients were Hispanic and Haitian. Even here now in Delaware, a lot of them are African American. We have Asian families that come in. So, there are lots of cultural differences that might be at play. If I don't acknowledge or recognize how some of those things might be influencing the room, then I could really miss an opportunity for intervention. So think about citizenship status, for a second. We may be talking to a family or a patient about all of the different resources that are available to them through the state and through various private funding agencies. That patient may not be capable of receiving access to those things, if they don't have legal status, here in the U.S. So thinking about how these things play a role and engage with your patients, is really important.

All right, so another component of mine, is this idea of duality of deafness. So if we think of this capital D, deaf cultural group and then there are those who don't identify as capital D, deaf. I am not a fan of this. I think this creates an unfair dichotomy of those who identify as capital D deaf, those who sign, versus those who don't. So on this slide here, we have a bunch of different areas in which deaf identity may play a role for a patient. So and I think this middle one is a little bit hard to read. Down here. Trying to grab my arrow. There we go. But education, working environment. So thinking about all of these different factors or levels, that a patient experiences, when they come into your room. Was it onset progressive? Was it sudden? Was it at birth? Was this acquired in adulthood? What is their language modality? Are they sign? Are they SimCom? Are they bilingual? Are they only spoken language? Do they engage with anybody else who might identify as deaf or hard of hearing? Stay engaged at all with deaf media or deaf culture? What assistant devices do they use? Do they have any deaf family members? These are all different areas in which a person's identity, particularly as it pertains to hearing loss or being deaf, is going to change. So again, how often are you thinking about these factors for your patients and if they are playing a role in the room? All right, so we've got another question here I'm gonna take a look at. "I'm a young female provider "and I feel some resistance to the idea "of asking permission to share information with patients. "Do you think there's some gender privilege "in the effectiveness of using this strategy?"

So thank you for asking that, I think that's a good question. I will say that the vast majority of providers that I work with, are female, even within behavioral health, within psychology. Many, many of them definitely use that strategy. When we are asking permission, I think you are likely to be okay, even as a young female provider, for two reasons. One, the patient is coming into the visit expecting to have information handed to them. It's almost like a duh question to them, because, they're like, "Yeah, of course "you're gonna give me information. "That's why I'm here." I actually think that's part of the reason why so many of them will always say, "Yes." It's like, "Yeah, you're supposed to give me info." What they don't realize is, I'm trying to get more buy-in from them. I think the other piece that comes into play is, you have that background, you have that audi or PhD, or whatever your training background is, kind of on your badge, or on your jacket. So, they are drawing that authority that you are speaking from your training background, not necessarily from your biological sex. That being said, I would be remiss if I did not acknowledge that as a male, it's probably easier for me to get buy-in from patients, than it could be for some women. So that's a really good question. I hope that answered it. All right. So engaging in behavior change. This is all the stuff I've been talking about now, right, thinking about that idea of, "How can I, well with resistance, "if education in and of itself is not enough, "what am I supposed to do?" So this model here Prochaska and Diclemente's Stages of Change, is one of the sort of pre-eminent, most popular models of thinking about behavior change in healthcare. This was created and developed specifically within the idea of physical health change, particularly smoking cessation. So Prochaska and Diclemente, created essentially six different stages of behavior change. We're gonna kind of rock through them in an example. So the first stage, would be pre-contemplation. That is, "I am not even remotely thinking about "engaging in any sort of behavior change. "The thought of it is not even on my mind." This would be probably maybe your friend who is complaining about their significant other, like, "He or she cannot hear anything and I've been "begging them to go and get their hearing checked "and possibly get a hearing aid. "They won't even bother to let me schedule an appointment." That would be someone who hasn't even remotely thought about engaging in any sort of behavior change, related to their hearing.

The next example would be over here, contemplation. So you are aware that the problem exists, but there's no commitment to action. So in that same example of the significant other, maybe now they recognize that their hearing is causing some problems, particularly when they go out, to say a restaurant or to dinner, or when they're with their family. But they really haven't thought through any sort of steps to possibly remedy that. I'm sure many of us audiologists probably had patients who come in and they're like, "Yeah, my significant other brought me in. "I don't really wanna be here." Maybe they say it bluntly like that, maybe they don't. So preparation. So this would be a patient who is now intent on taking action to address a problem, but they haven't actually taken any steps. So that would be, "Yeah, I'm gonna schedule "an audiology appointment." Or, "I'm open to getting hearing aids. "We already met with the audiologist, "but we haven't submitted the order for them, "or haven't given them the go ahead to get the devices." So they're thinking about taking action, they wanna take action, they're probably gonna take action within the next couple weeks, but they haven't done so yet. Action would be, "All right, now I'm ready to "engage in some behavior change "and I'm actively doing that. "I'm wearing my hearing aids a little bit more. "I'm trying a new FM system." Something to that effect. Maintenance would be, "I've engaged in behavior change "and I am now maintaining it and going forward. "I've maybe done this behavior change for a year or two now."

Then relapse would be kind of falling back into that old pattern. It applies differently for different situations. So for example, drinking or smoking cessation, you can think about relapse very easily. With hearing loss, it might be something like, they were wearing their devices more and now they're not. So where we run into challenges as providers sometimes, is we might have patients that are over here, in the contemplation stage, or the preparation stage, but we are talking about engaging them in ways that are over here in the action stage. So maybe a patient comes in and they're thinking about getting hearing aids for the first time, or thinking about a cochlear implant. But we are already talking about next steps, in terms of action and setting up surgery dates and getting the MRI and all of that. But that patient does not wanna move forward, they're not ready. If you are experiencing resistance with a family, one of the things I might ask myself, or yourself is, "Where in this stage of change model, "is my patient?" If they are not over here in action phase, or preparation phase, "What can I do to help them move "a little further along this spectrum?"

So, here's the example. Eliciting change talk. I love doing this, this is really cool. I think it's fascinating when I've done it with younger children and their parents, teenagers, they are often, I think it gets a lot of really interesting information and the families are like, "Oh, I didn't know that." So motivational interviewing. This is one of your questions here. Motivational interviewing is a process, where by we are acknowledging that there is some sort of ambivalence that is going on within a person, regarding a behavior change. In the case of possibly using hearing aids more frequently, or getting an implant, we think of it as very, very rarely that a person is actually, truly 100% firmly committed against the idea, or firmly for the idea. There is usually some sort of ambivalence, that is going on there. So motivational interviewing is a way of increasing that ambivalence, to help a person be ready to move on some behavior change. So I'm gonna walk through this example. I'm gonna take to be what I find to be one of my most challenging types of cases, would be a let's say a tween, we'll call them 11 or 12 years old, who comes in and mom and dad are kind of exasperated, because they want the kid to be wearing the hearing aids more often in school and the kid at this point, just flat out refuses. They will not put them on. You have seen them for a program in session, but in your brain, you're like, " I know "they're not gonna wear it, they haven't worn it "for the last year." So you have two options as a provider. One is to treat the hearing aids and program them from a technical standpoint and give them back to the kid and send them on their way, see them in six months. The other would be to really try and spend some time rolling with that resistance and flushing out what some of the challenges are.

So, what does this actually look like? So I have, let's say, I'm gonna call him Mike, I'll use my own name. Mike comes in and he's with me, he's kind of got his arms crossed, he's clearly not really ready to talk. "Hey Mike, I know you probably don't wanna be here today. "I really appreciate you coming in. "I'm sorry your mom and dad kind of dragged you in." "Hmm, okay." "Is it okay with you if I just ask some questions "to get to know you a little bit better? "I myself have hearing loss. "I know what it was like to grow up with that, "but I don't really wanna pretend that I know "exactly what your experiences are. "What you've gone through and what I've gone through "are probably different "and we probably have some things in common." "Yeah, okay." "All right, so you know Mike, "I'm just wondering from your perspective, "can you help me understand, on a scale of one to 10, "if 10 is like absolutely 100% I cannot wait "to wear my hearing aids I'm gonna put them on "the second I walk out of this room "and a one is like, "No way, Jose. "Never in a million years will I ever "put on my hearing aids. "I wanna go throw these in the trash "and run a truck over them." "Where are you on that scale of one to 10? "How much are you willing to use the hearing aids?" "I don't know, I'm like, a two or a three, I guess." "Okay, great. "Thanks for sharing that with me. "Why would you say you're a two or three? "What made you pick that?" "Well, you know like, yeah they can be helpful, "but I just don't wanna wear them." Well here I might reflect back. "Okay, so you know there's some benefit to them, "but there's also a challenge for you in wearing them." "Yeah." "Would you mind being a little bit more specific about "what those challenges are?" "Yeah, well like you know, it's just like super loud "in the classroom and super annoying there. "And like in the lunch room and I just hate "carrying the FM system from teacher to teacher." "Okay yeah, thank you for sharing that with me. "So I don't know, if I had a magic wand I mean I obviously don't, but if I could make like "the issues with carrying the FM system "from classroom to classroom go away "and you didn't have to worry, "we could fix that issue with the noisiness in the "lunch room or the classroom, "would you be willing to wear them?" "Hmm, probably not, no." "Okay, so I guess there's something more there, "than beyond just those two issues." "Yeah, maybe." "Is it okay if I tell you a little bit about "what I hear from some other kids I work with?" "Sure." "Okay, well you know, a lot of the kids I work with, "especially in your age range will say, "they don't want others seeing them or asking them "about their hearing aids, "or like asking questions about it. "They kind of feel embarrassed carrying the FM system. "Is that at all true for you?" "Yeah, yeah, that's some." "Okay, I really appreciate you sharing that with me. "All right, so I just wanna jump back to that scale. "When we were talking, you had said you were "a two or a three. "Can you help me understand why are you a two or a three "and not just like a one. "There's something there." "Well yeah, I mean like I've worn them before, "and I know it helps make it a little bit easier "to hear sometimes in class, when I have them on. "I just don't like wearing them." "Okay, yeah. "Thank you for sharing that.

"Any other reasons why you're a two or a three "and not a one?" "Well also like it makes it a little easier "to listen to music, sometimes." "Yeah, all right, that's totally fair. "What do you think it would take "to get you from like a two or a three, "to maybe like a five or a six? "I don't expect you to be at a 10, "but what would it take to get you back up "to something like a five or a six?" "Well, I don't know like, could we like, "I don't know. "Is there a way to like do something about the FM system?" Here as an audiologist, is your chance to say, "Hey I can give you some more information on that. "We could definitely talk about that, "if that's okay with you." "Yeah." "Anything else we could do to get you "from a two or three to a five or six?" "I don't know like, maybe we could not have to "carry the FM system?" I'm gonna pause there. Take a second, think about that, but hopefully, it will get you thinking a little bit about this. Probably really different than conversations you might usually have with a patient. So a few things I did in there. When I asked, "Why are you a two or a three, "and not like a one?" What this does, think about that. What that does for a patient, is forces them to explain in their own words, why hearing aids might be helpful for them. We know from health behavior change, that people are more likely to engage in a change, when they themselves are discussing the reasons that they need to make a change, not hearing it from us as providers, who are lecturing at them. So I got him to talk a little bit about reasons why he wasn't a one. Also, I said, "Hey, what can I do to get you "to a five or a six?" I was asking, "What do you think you need, "what can we do to help you make a change?" All of these things were pulling information and getting data that I can use to adjust either the programming of the hearing device, maybe the FM system, or think about other sources for referrals. Other questions that I didn't build in here. "Well why do you think others are concerned about your behavior?"

So if a patient tells you like, "Oh, I don't know, I just don't wanna wear them." Say, "All right, that's fair. "Could you tell me, I don't know, "why do you think your mom is like so bothered by this? "Or why do you think this is so frustrating for your dad?" Again, I'm using that same strategy that I used up here. I'm getting them to talk about reasons why they might wanna improve or change their behavior, so. Let me, I may add another note for this one. This is not easy. This is very difficult kind of way of engaging with patients and it probably feels super squishy and super different from the way that you have done that previously. So there's a book, I have it coming up in the later slide. It's about motivational interviewing. If you're super interested in learning more about that, I would suggest reading it, checking that out. So, okay we have a question. "What do you recommend for patients "that are in complete denial of their hearing loss, "when it is fairly significant? "As in they blame others that they mumble, et cetera." Yeah, so that's a really good question. So what I would do is, a couple of things. I would one, very similar to what I did here. Try and get a patient to think about, why others are raising this issue, or why they're coming in. Another thing you can do with them is say, "Hey, so what do you think will happen, "if you don't change?" This question right here. "Well, yeah I mean, nothing maybe, "but people are just gonna keep mumbling "and like talking and like I'm never gonna hear "what they say and it's frustrating. "It's super annoying. "Other people just need to speak up." It's like and then I would reflect that back to him. "Yeah, wow that must be really frustrating. "It really sounds like you're struggling "when you're with your family, "or when you're at work, or when people are mumbling, yeah. "So I don't know, that must be really kind of upsetting you, "if you think about just like going forward, "people are just constantly mumbling "and you're not able to hear them." "Yeah." Then you can kind of keep opening the door a little bit, from that perspective. You can kind of turn to the significant other, "I don't know, is it okay "if we get your significant other's perspective, "or your family member's perspective, "or your child's perspective?" And also let them offer information. Then you're opening the door for conversation. Invariably, there will always be some patients who are 100% just not ready to engage in behavior change and that is okay.

If you detect, if a person's like, "I'm on one", and they are not budging off of that at all, then you are recognizing in that moment, that that person is not ready to engage in change. They're not gonna be receptive to any of the strategies that you have to use. What I would do is, shift my thoughts to, "How do I preserve the alliance with the patient right now? "Thank you so much for coming in, "I really appreciate it. "I know you really don't wanna be here. "Is it okay if I just show you what "some of the options are? "You can take it home, you can look at it. "No pressure, I'm not trying to force anything on you." "Sure." "If at some point, you ever wanna come back, we're here." What you will do in that moment, is leave the door open for that patient to come back, because they at least felt heard, than if you just throw all the information at them, while they're in denial, so to speak. Okay, so we had another question here. Yes, the name of that book. It's coming up. It is quite literally called, "Motivational Interviewing." Let me jump forward, so you can see it. Yep, this is it. "Motivational Interviewing", third edition. William R. Miller, Stephen Rollnick. There's also a bunch of other versions of that out there. So check it out, read it. It is not written specifically for psychologists. It is written specifically for healthcare providers. All right, "So wondering about parents who are in denial "of children with significant hearing loss." That is a really tough one, yeah. So I am going to kind of fold that in, to one of the other case examples I had up here. Let me get to where I wanna be. Okay, so I'm gonna skip forward a little bit, hold off on that first case example. I'm gonna jump here. When we have those new diagnosis families. Because I think the question was, "What if you have a parent who's kind of in complete denial "about hearing loss?" I think more often not, that is going to come up, early on in the process for the child. So what we think of, what I've experienced. So for new diagnosis families, they've just learned about maybe a failed ABR, the confirmation was there, they've got a couple hearing screenings, they don't wanna come in. So we put ourselves in the perspective of that family. We know that many of them are experiencing guilt, or they're mourning that kind of change in the expected trajectory of this child's life course. They just don't know what's going on and they're not sure how this hearing loss is going to impact the person. So it may be that the thought of acknowledging or recognizing this, is really, really painful and hurtful for them.

So, what I've experienced from a lot of families, are a lot of questions, not only around technical issues and aids and technology, but social functioning. Will my child make friends? What will others think about them? Will they ever date? Will they get married, right? So parents' brains seem to rush, 10, 15, 20, 30 years in the future, of really all these events that are going to happen, for their kid. So, when we have these new diagnosis families, even one who might be kind of in denial, I think it requires a slight shift in thinking. It feels minor, but I think it can go a long way. So our goal shouldn't be to make them feel better. "Oh it'll be okay, don't worry about it. "Like, your kid's got a mild unilateral loss. "I've seen way worse." Okay, our goal should really be to make them feel heard. If we think of ourselves as trying to make them feel better, then what we're doing is closing the door for that family to express what they're going through, by trying to kind of rush them to a better, happier space. And a family may not be there yet. So in trying to make them feel heard, if I have a family who say, say I'm the ABR audiologist and I'm giving them the results of the ABR. I'm gonna pause for a second and say, "You know, I know that was a lot of information. "Is it okay if I ask what is going through your mind?" Again, I'm asking permission. I'm gonna normalize and validate the heck out of those feelings. "So yeah, I totally get it." Many parents often describe to me that this just feels like kind of a loss. Like the things that they imagined for their kid are changing. I'm gonna use reflective language again. "So yeah, if I'm understanding you correctly, "like you're really kind of wondering "what it's gonna be like for them "when they go in school, or how they're gonna do "with other peers, things like that." Again, you're gonna elicit more information. So trying to make them feel heard, is gonna be really helpful. What I do wanna avoid with new diagnosis families, is specific targeted information. It's not gonna pull for more information, or targeted questions, I'm sorry. It's not gonna pull for more information, it's not gonna get you more engagement. I don't wanna ask close ended questions, where you're just pull for a yes or no response. I don't wanna just bombard the family, with my previous professional experience. "You know, I've been doing this for 30 years "and I have no doubt that your kid is just gonna be fine." Because again, I'm not giving them that space to be upset. Instead, I might say something like, "You know, I'm gonna be here and you're gonna have "the full weight of this hospital behind you, or clinic, "to support you in whatever steps come next."

All right, so I did wanna get to this question that we had put on hold before. But this is the book again, "Motivational Interviewing." I'd say if you're interested, check it out. All right, so I'm coming back to this question that we had previously. All right, "So how might an audiologist "help a patient who comes in for "a hearing aid consultation who insists on "determining their own method of fitting? "But you know it's very inappropriate "and to you that may feel in the words of this question, "unethical, to offer that fitting. "You try to gain information on why they would feel "this is best for them and you slowly transition them "to a more suitable path. "And your patient realizes the recommendation "just doesn't apply for them." So that's a really good question. What I would think about is, going back to the motivational interviewing component of, what is driving that kind of desire? I would call it out to them. That is a patient, to me, who sounds like they are not quite ready to hear what might be best. Again, providing that education is just not gonna do anything for them. So saying to them, "Can you tell me some reasons "as to why you think this fitting method would be best, "like you described?" Eliciting as much information as possible. Then trying to figure out what's underlying that. So they're saying, let's say it's a profound loss, and they wanna like in the ear that's just not appropriate. Really try and understand what the motivation behind some of their requests are. "So you're telling me that you really want "something that's completely insertable within the ear canal "and you're just totally against having it behind the ear "hearing aid, or even thinking of something "like a cochlear implant. "Okay, I really appreciate you for sharing that with me. "So I just wanna understand a little bit better "where you're coming from. "Why do you think that in the ear would be best?" They tell you it's just subtle. "I don't want other people to see it. "I think that would be smaller." "Okay, so it sounds to me like "there's a part of you that's kind of concerned "about the physical appearance of the device, "or the aesthetics of it and that must be hard." "Yeah."

So if you can elicit some of that reasoning, or the motivation behind why they're doing that, then you wanna put that in contrast with some of the other kind of expressed desires or motivations for them and again, we're raising ambivalence. So this is what you do. You would say something like, "On one hand, I hear that you're really quite "kind of nervous or concerned about "other people seeing the device and asking about it. "But on the other hand, I think you also want to "improve your hearing to some degree. "I mean you're obviously here for a reason." "Yeah." "So it seems like in our conversation "that your focus on possibly keeping it "as minimally visible as possible, "may also be making it harder for the hearing aid "to actually help you in the way that I think "might be best." So again, raising some sort of ambivalence between their two kind of stated desires. One is to minimize the appearance and the other is to get some gain, or some benefit. They must have some ambivalence, because they're obviously there for the appointment. But it's a tough one, it's a tough line. I would also think back about that patient may not be ready to receive all of the information you have to offer them. So preserving that alliance, giving them the materials that you can and then saying, "Hey, you know, "if you wanna discuss this again, come back." You wanna leave that door open for them to return, and not just say, "Here's all the information, "I'm not gonna fit you with this device." So, good question. Other thoughts, other questions. We have a couple minutes left. I'm happy to answer them.

- [Christie] Thank you, Dr. Hoffman, for such a--

- Yeah it doesn't look like much is pop--

- For such great insight.

- Yeah.

- We're gonna open up the floor to see if there's any other comments for Dr. Hoffman. There's just a couple minutes left before the top of the hour. We wanna thank you again, for just coming on and sharing your knowledge with us. I think this is gonna be serving as a great resource for the clinicians.

- I appreciate that. Thank you so much. I appreciate your time and everyone coming in. I know it's an unnerving and stressful time out there. So to be part of this and hopefully get something out of it, is helpful.

- We have a couple comments rolling in from the members. They're just mentioning that it was very well spoken and they also appreciate the information. They appreciate the discussion on allowing people to grieve. We are uncomfortable with that as a culture and I would agree with you, Kimberly. Just a couple more thank yous for you, Dr. Hoffman. Dr. Hoffman also included his contact information there. So if you think of another question or comment, after the fact, I'm sure that he would welcome comments or questions. Isn't that right, Dr. Hoffman?

- Awesome, thank you, guys. Like I said, like she just said, please feel free to reach out to me, any questions, I'm always happy to talk. Always happy to chat. I know these are not easy things to do.

- [Christie] We hope you guys enjoyed this resource and I hope that you have a wonderful day. Thank you so much.