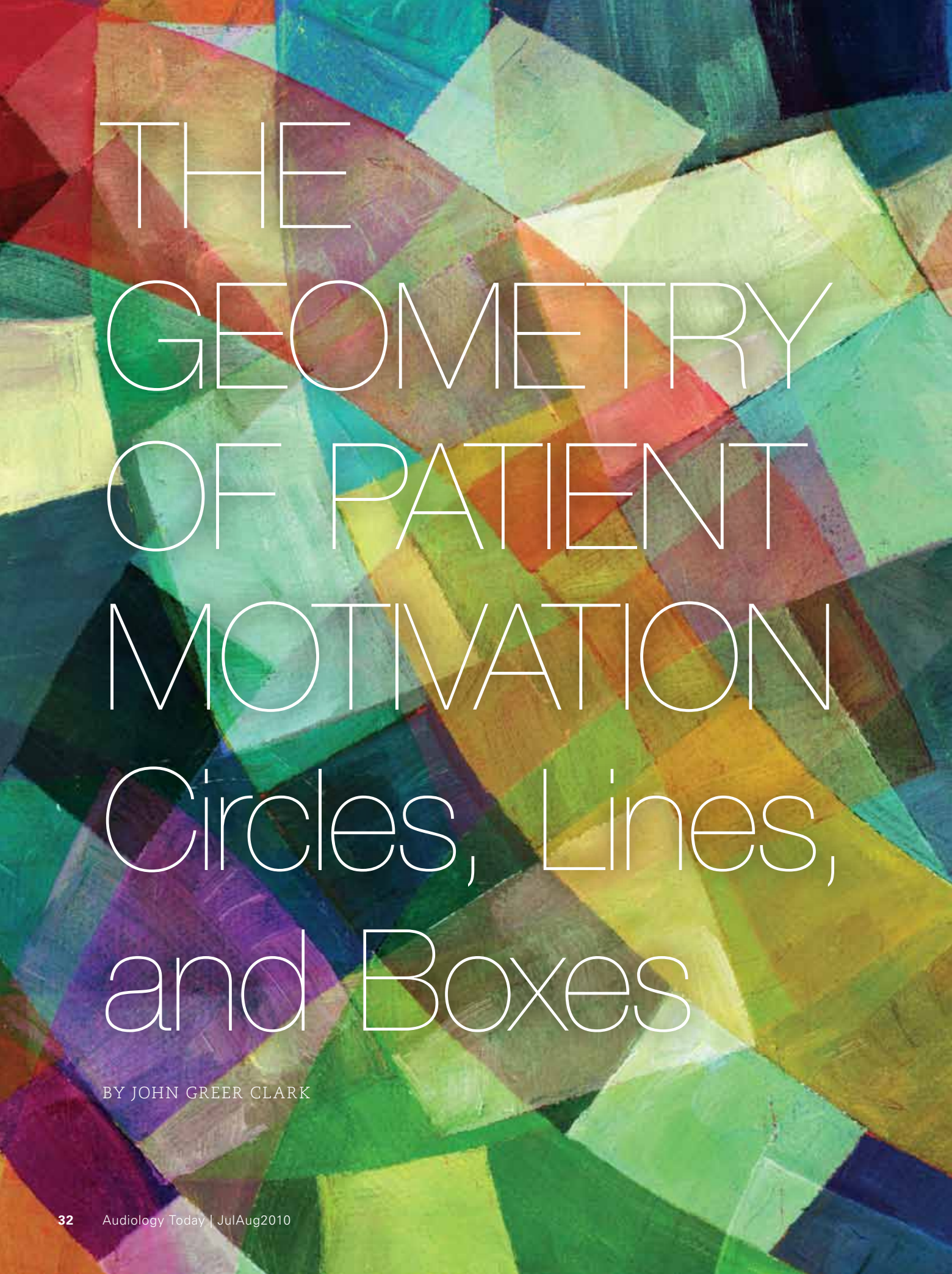

THE GEOMETRY OF PATIENT MOTIVATION

Circles, Lines, and Boxes

BY JOHN GREER CLARK

This article relays a set of simple tools represented by three geometric symbols that, with a little practice, audiologists can use effectively to help patients build their own internal motivation for hearing help.

It has long been recognized in health-care arenas that change does not occur without motivation for that change. This holds true when dealing with substance abuse issues, medication compliance, eating disorders, change in diet, smoking cessation, exercise regimens, or any host of health-related issues. Audiologists have also long recognized that patient motivation is a key to one's acceptance of hearing care recommendations.

Frequently, audiologists find themselves going to great lengths to develop ways of motivating their patients toward action. We often counter patient resistance to our recommendations with discussions of the patient's audiogram and the implications of measured hearing deficits on speech reception. Often, we will provide third-party stories of successful patients who had once questioned if they needed amplification, yet who are now quite successful hearing aid users. We may use hearing manufacturer marketing slicks that employ celebrity endorsements to support a product. We may even embrace the age-old sales tactics of financial inducements, offering limited time discounts or savings with binaural fittings. In spite of our efforts, we often find that reluctant patients operate on their own internal timetable and are only ready to proceed when they feel the necessity. Like our patients' family members, we are at times baffled that these patients do not seem to acknowledge the same communication frustrations and urgency for action that seem so apparent to others.

In actuality, clinicians can only set the stage for patients to find their own internal motivation to tackle the tasks required to achieve desired goals. It becomes the audiologist's role to help patients recognize the negative impact of untreated hearing loss and to articulate their own reasons for change. As we might recognize from our personal life experiences, motivation that arises from within oneself is far more sustainable and leads to far greater successes than motivation that another person attempts to instill within us.

The need for audiologists to successfully kindle patients' internal motivation has been a recent topic in audiologic literature (Harvey, 2003; Beck et al 2007; Beck and Harvey, 2009) and in a series of interactive workshops for hearing health professionals (idainstitute.com). The purpose of this article is to relay a set of simple tools represented by three geometric symbols that, with a little practice, audiologists can use effectively to help patients build their own internal motivation for hearing help.

Setting the Stage

Theodore Roosevelt said, "People don't care what you know until they know that you care." Toward this end, the manner in which we attend to our patients' needs, draw out their stories, and provide a true listening rooted in understanding is critical to setting the stage for successful engagement and the attainment of clinical goals (Clark, 2008). Patients present various levels of readiness to engage within the clinical process. It is our challenge and goal to help them to find, when lacking, the internal motivation to accept our recommendations and move forward.

More than a quarter of a century ago, Goldstein and Stevens (1981) presented four postures of readiness toward hearing loss management that patients may bring to the clinic. Those in the first posture, representing the vast majority of the patients coming for audiological services, are generally positive toward rehabilitation and ready to work with the audiologist. Those holding the second position in the Goldstein and Stevens categorization also bring a positive outlook toward hearing loss intervention but may present a complicating factor (e.g., a hearing loss that may be difficult to fit with hearing aids or a concomitant complicating health condition). While those with the third posture may be generally negative toward

the idea of hearing rehabilitation, they demonstrate a willingness to work within the process. Audiologists are fortunate that those holding forth this third posture, and those of the fourth posture, who present an open rejection of hearing aids and hearing rehabilitation, constitute the minority of the patients we see. Those in these latter two groups present our greatest challenges and our greatest disappointments, as they frequently depart from the clinical visit without committing to the steps they must take and their family members strongly desire. It is for these latter two groups of patients that motivational engagement strategies are most useful.

Audiologists must combat common human emotions and behaviors that may adversely impact the services they deliver.

Audiologists, just as other health-care professionals, must combat common human emotions and behaviors that may adversely impact the services they deliver. We frequently see patients with long-standing denial, a resistance to change, skepticism toward diagnostic findings and recommendations, or ambivalence toward the actions they know they should take (Clark, 1999). We may even perceive these individuals as negative or unmotivated. Yet all such emotions and behaviors are normal responses to unwanted change. As Rogers (1951) advises, we must grant a full acceptance of our patients and the stage they are within on their personal life's journey. We must not only accept patients where they are, but also, though active listening, demonstrate that acceptance and understanding.

It is a sincere understanding and recognition that all patient emotions and accompanying behaviors are normal responses to unwanted change that fosters a positive engagement between audiologists and their patients. However, clinical success is predicated on more than the positive engagements we can establish. For those patients who fall within the third and fourth categories outlined by Goldstein and Stevens, we must also find effective strategies to help patients develop the internal motivation for self-improvement that is at the root of desired clinical outcomes.

Motivational Engagement

As much as health professionals wish to believe to the contrary, clinicians can rarely motivate patients to take sustainable action, as such motivation can only arise from within a person. Through motivational engagement, the audiologist's role becomes one of facilitative coach as patients are guided to reflect on the impact of hearing loss, the costs and benefits of action or inaction toward effective remediation, and patients' willingness and perceived abilities to make positive changes in their lives.

While there are many approaches to guide others in self-reflection toward motivation, a powerful method for clinical audiology is brought forth through three simple geometric figures—circles, lines, and boxes. Hanne Tonnesen, a physician with the World Health Organization's Collaborating Center at Bispebjerg University Hospital in Copenhagen, has used these tools to help patients make powerful changes in their lives when confronting health issues such as necessary dietary changes, medication compliance, smoking cessation, and others. She helped bring these "tools" to audiology's attention through her collaboration with the Ida Institute.

Circles

It is through the understanding gained by listening to patients' stories, often facilitated through discussions of reports on self-assessment measures, that the audiologist can gain insight into how prepared a patient is to make the changes required for improved hearing. The circle of change not only helps the clinician to visualize better the patient's preparedness for change but also to determine if change is required in the attitudinal or behavioral domain (FIGURE 1).

Patients who are not ready for making the changes requisite for success (those who are in the final two categories of Goldstein and Stevens' readiness ranking) fall into one of two areas. Those in the pre-contemplative behavioral stage may fail to admit, or sometimes even recognize, that a problem exists and only come for evaluation at the behest of another. Those in the contemplative stage may recognize

that there is a communication problem but may not fully agree where the problem originates (e.g., others mumble). Those in either stage, as well as those who are preparing for change, need further information to help them to move forward, and it is our task to listen effectively and provide information in a clear and concise manner.

During these early stages we often must help patients increase their own appreciation of the personal impact of untreated hearing loss. Unfortunately, if the information and subsequent recommendations we provide are presented when emotions are high (e.g., following confirmation of hearing loss), patients may not be able to attend fully to the problem-solving recommendations the audiologist provides (Cahill et al, 1995; Canli et al, 2000; Richardson et al, 2004). The timing of information delivery suggests that before we proceed with details, we ask patients and attending communication partners if they have any questions about any overview statements we have made, or if they have any other questions on their minds. The questions patients have for us may be related to progression of the loss, hereditary issues, cost of hearing aids, unilateral or bilateral fittings, or any host of other possibilities. But until these are addressed, we fail to have their full attention for any details we may wish to present.

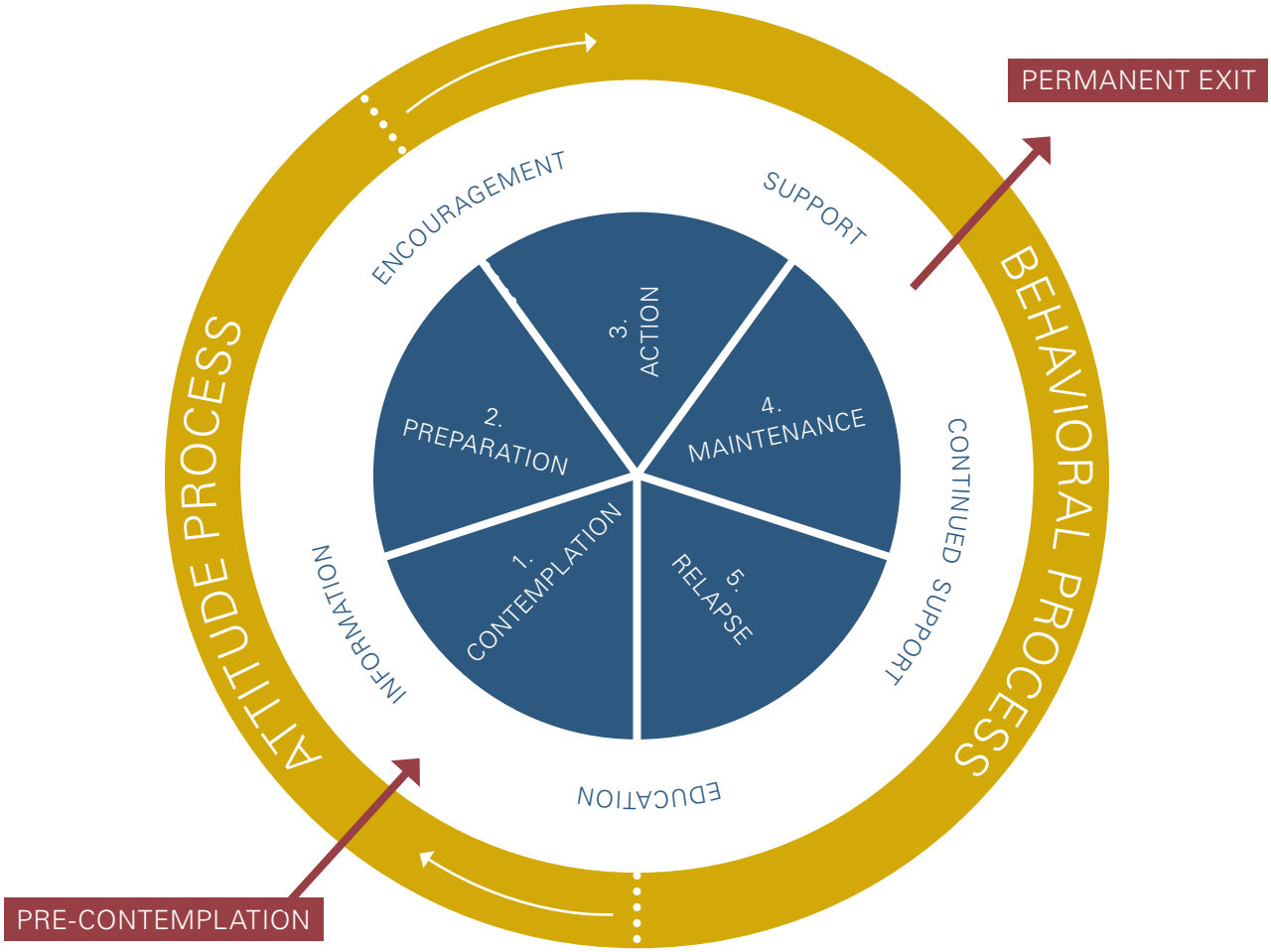

FIGURE 1: A cyclical representation of the stages of change that patients may confront when considering aspects of audiological treatment. Stages one and two require changes in attitude toward hearing loss or treatment avenues. Stages three through five represent stages requiring modification of current behaviors (modified from Prochaska and DiClemente, 1984).

When patients reach a level in which they are either prepared to make a change (move forward) or are actively proceeding with the recommendations given, our greatest assistance comes through encouragement focused on the benefits of the change they are moving toward. Finally, once a patient has been fit with hearing aids, it is vigilant aftercare that ensures continued follow through with hearing aid use and augmentative rehabilitation recommendations so that the patient does not relapse in the efforts that have been made.

While we frequently can tell where a patient resides on the circle of change quite early in a clinic appointment, sometimes we are not aware of his or her readiness ranking until we present our initial recommendation. As stated earlier, when motivation and readiness are low persuasive arguments, celebrity endorsements, third-party stories, and financial incentives frequently do not provide the inducements we may desire. Those within the stages of contemplation and preparation within FIGURE 1 are not quite ready to take action and with guidance need to reflect on the attitudes they hold toward hearing care and the need to change. An effective means to guide patients through constructive reflections can be achieved with the remaining two geometric forms—the lines and the boxes.

Lines

A visual tool to reflect on one's position on a given issue can generate needed focus and an opportunity to explore the directions one is choosing to take in life. The use of a of two lines representing a graduated scale from 0 to 10 (FIGURE 2) allows for a powerful visual "thermometer" to provide a ranking of (1) the perceived importance to make a change in one's life, as well as (2) a ranking of one's perceived ability to make changes (Rollnick et al, 2008). In audiological practice, the use of these lines is most effective in conjunction with discussions that may have evolved through self-assessment tools. The introduction of the lines may be as straightforward as the following:

Clinician: We've been discussing some of the frustrations you've had at home when talking with your wife. She seems to think it's all related to your hearing, but you think it is as much, or maybe more, the way she talks to you. Do I have that right?

Patient: Yeah. Like I said, she starts talking to me when she's in the kitchen and I'm in another room watching TV. Or with her head in the fridge. Nobody's going to hear someone like that.

Clinician: I agree. We also talked about your hearing and the fact that you have some hearing loss. But clearly the frustrations you're having seem to come from more than just your hearing loss alone. Take a look at this scale with me for a second. (Bring out the first line.) Given the frustrations you and your wife are having, how important is it to you to make life better. Zero (point to the 0) means making things better is not important to you or your wife and that everything is fine with the frustrations the way they are. Ten (point to the 10) indicates that it would be highly important to you and your wife to improve the situation at home. Can you take this pen and mark on the scale how important you think making a change would be? (Depending on the comfort level the patient has with the clinician, it may be awkward to ask the patient to mark on the line, but the active engagement of the patient at this point has been shown to strengthen the outcome.)

The key to success in using this first line is the earlier identification of some life issues that are impacted by the decreased communication function the patient/family is experiencing. If properly identified, patients will most

FIGURE 2. Use this scaling line with patients in two steps: (1) Have patients self-rank their perception of the importance of change in their lives and then (2) have patients rank their perceived abilities to make a change. The scale ranges from 0 "not at all important" or "not likely to be able to make a change" to 10 "very important to make a change" or "highly likely that a change can be made" (Rollnick et al, 2008).

Acknowledgement simply provides needed recognition and that what we are asking people to do is not always easy for them.

frequently rank importance of improvement relatively high (i.e., seven or above). If the ranking is lower than seven, the clinician may follow up with the question: "What can I do, or answer for you, that might move you higher on the scale?" If the patient has no concrete suggestion, it is time for the clinician and patient to engage the "box" to build better motivation to move forward, and the second line can be bypassed for the present time.

If the ranking on the first question is high, the clinician can move directly to the second question:

> **Clinician:** Let's look at another line scale for a moment. How likely do you believe you will be able to follow my recommendations, which might include using hearing aids, so that we can make your quality of life better? Zero would be not likely at all, and 10 would be highly likely. Can you mark this line for me?

Answering this second question begins to direct the patient toward reflection on the difficult processes often involved in changing behaviors. If the ranking on this question is also high, there is no reason to engage the boxes with the patient.

If the ranking for the second question is low, an appropriate follow up question would be: "Why do you think your abilities for this are so low?" The ensuing dialogue may uncover fears of technology, concerns of what others will think if hearing aids are worn, previous failure to follow through on difficult tasks, or some other concern. The clinician's task at this point is simply to acknowledge these concerns and reassure the patient that to some degree these issues are resolvable and that the clinician will be there to help every step of the way ("*Considering making a change like we are discussing such as using hearing aids can often be very daunting*"). We must recognize that

acknowledgement of another's concerns does not imply that we believe they are valid or that we agree with them. Acknowledgement simply provides needed recognition that we understand that what we are asking people to do is not always easy for them.

Boxes

Like the lines, boxes provide visual tools to help patients place their hearing loss into a more meaningful framework. The boxes are useful primarily for those patients who rank themselves low on the need to make a change. The dialogue may go something like this:

> **Clinician**: You don't seem to believe it's important to make any changes to improve the communication problems you're having, and maybe it isn't. But from what we've talked about (often first uncovered through completion of one of many available self-assessment scales) it seems something needs to change. For a moment, let's look at a framework that can help us sort out the advantages and disadvantages of change. Looking at this box, tell me what advantages you see for your life if you do nothing to address your hearing problem.

Directing the patient's attention to the upper left quadrant of FIGURE 3, the clinician helps the patient explore what the advantages of inaction are. It is important at this point for the audiologist to wait for the patient's lead. Audiologists, like most other health-care providers, are accustomed to leading the dialogue. However, as stated earlier, motivation comes from within. The thoughts that fill the quadrants of the box have far greater motivational power if they are the patient's thoughts. The upper left quadrant may be filled with items reflective of the comfort of leaving things the same, the safety in knowing that there is no need to learn anything new, or the money

BENEFITS OF STATUS QUO	COST OF STATUS QUO
POTENTIAL COST OF CHANGE	POTENTIAL BENEFITS OF CHANGE

FIGURE 3. A decisional balance box to guide patients in their own exploration of the pros and cons of inaction versus. forward movement (Janis and Mann, 1977).

saved by not purchasing hearing aids. The items placed in this square are most likely true concerns for the patient and should be acknowledged as such.

After reflection on the benefits of maintaining the status quo, attention is directed to the costs of inaction (upper right quadrant). Again, it is important that the audiologist takes a backseat and allows the patient to think of the costs of their hearing loss. Surveys reveal that audiologists most frequently do not engage the spouse in the hearing consultation process (e.g., Stika et al, 2002). However, it is readily apparent that reflections will be more fruitful with both communication partners drawn into the process. This quadrant may be filled with items that recognize the continued frustrations at home when misunderstandings occur, arguments arise due to hearing loss, become unable to hear grandchildren or withdraw from social activities, or any number of consequences of hearing loss. Asking the patient to look back at the previously completed self-assessment form can further facilitate this exercise. Completion of the final two quadrants in the box flows readily from the items in the first two quadrants often providing mirror images to the items previously written down.

Once the boxes are completed, it becomes apparent to all parties that the costs of inaction and the benefits of moving forward far outweigh the costs incurred by working toward solutions, or the benefits of the status quo. At this time, a reexamination of the first line will most often reveal a significant shift to the right for those who previously rated a need to change as a low priority.

Conclusion

Audiologists have frequently attempted to motivate their patients through traditional sales techniques, which often include financial incentives, celebrity endorsements, compelling arguments, and persuasion. However, the greatest source of motivation and the convincing arguments for change most always arise from within patients themselves.

Identifying the personal impact of hearing loss through guided discussions and active listening puts the audiologist in the position to ascertain where patients are on the circle of their own personal journeys from pre-awareness of their hearing loss to acceptance and recognition of a need to take action.

When patients believe they are not ready to move forward with a hearing rehabilitation plan, the use of the box tool may help patients plot their own cost-benefit analysis and will frequently give them the opportunity to weigh the pros and cons of inaction versus action, an exercise that most often leads to action.

Further discussion on the use of the circle, lines, and boxes, and other tools to meaningfully engage your patients, are available on the Ida Institute Web site: www.idainstitute.com.

John Greer Clark, PhD, is an assistant professor with the Department of Communication Sciences and Disorders at the University of Cincinnati, Cincinnati, OH.

The Ida Institute, founded with a grant from Oticon in 2007, is housed in Naerum, Denmark. The institute works collaboratively with international hearing care professionals to develop and disseminate tools to help forge professional/patient partnerships for exploration of the personal impacts of hearing loss and the effective rehabilitation of resultant communication difficulties. The author, along with David Fabry, PhD; Lorraine Gailey, PhD; and Hanne Tonnesen, MD, head of the World Health Organization's Collaborating Center in Copenhagen, Denmark, served on the Ida Institute faculty for the series of seminars titled "Motivational Engagement."

References

Beck DL, Harvey MA. (2009) Creating successful professional-patient relationships. *Audiol Today* 21(5):36–47.

Beck DL, Harvey MA, Schum DJ. (2007) Motivational interviewing and amplification. *Hearing Review*. http://www.hearingreview.com/issues/articles/2007-10_01.asp.

Cahill L, Babinsky R, Markowitsch HJ, McGaugh JL. (1995) The amygdala and emotional memory. *Science* 377:295–296.

Canli T, Zhao Z, Brewer J, Gabrieli JD, Cahill L. (2000) Event-related activation of the human amygdala associates with later memory for individual emotional experience. *J Neurosci* 20. RC99:1–5.

Clark JG. (2008) Listening from the heart. Audiology Online. http://www.audiologyonline.com/articles/article_detail.asp?article_id=2095.

Clark JG. (1999) Working with challenging patients: an opportunity to improve our counseling skills. *Audiol Today* (11)5:13–15.

Goldstein DP, Stevens SDG. (1981) Audiologic rehabilitation: management model I, *Audiology* (20):432–452.

Harvey MA. (2003) Audiology and motivational interviewing: a psychologist's perspective. Audiology Online. www.audiologyonline.com.

Janis IL, Mann L. (1977) Decision Making: A Psychological Analysis of Conflict, Choice, and Commitment. New York: Free Press.

Prochaska JO, DiClemente CC. (1984) *The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy*. Homewood, Illinois: Dow/Jones Irwin.

Richardson MP, Strange B, Dolan RJ. (2004) Encoding of emotional memories depends on the amygdala and hippocampus and their interactions. *Nat Neurosci* (7):278–285.

Rogers C. (1951) *Client-Centered Therapy*. Boston: Houghton Mifflin.

Rollnick S, Miller WR, Butler CC. (2008) *Motivational Interviewing in Health Care*. New York: Guilford Press.

Stika CJ, Ross M, Cuevas C. (2002) Hearing aid services and satisfaction: the consumer viewpoint. *Hear Loss* (SHHH, May/June):25–31.

Also of Interest

"Externalizing and Personifying Hearing Loss: A Psychological Tool for Audiologists," by Michael Harvey (*AT* March/April 2010): Log in to www.audiology.org and search key words "Michael Harvey."