
a psychologist's perspective

"But if you didn't want hearing aids, why did you make an appointment with an audiologist?" I asked. Joan saw no contradiction.

"My son, Mr. Know-it-all, had been badgering me for years. I just wanted to shut him up!"

"Did you tell the audiologist about your son?"

"No, I just told him I wanted hearing aids."

"But you didn't want hearing aids!"

"That's right, you aren't listening! I just told you I wanted to get my son off my back!" Now she was getting irritated with me.

Joan was right. I wasn't listening, or at best, my voice had an edge to it. And unlike most audiologists, listening is what I get paid for! CPT Procedure # 90806, a 45-minute individual psychotherapy session. But it had been a long day. I thought of similar complaints from health-care providers of the constant barrage of rushed, back-to-back appointments – never mind the paperwork and billing hassles that only get worse since managed care. As one audiologist put it, "I don't have the luxury of listening."

If, in my "user-friendly" context for listening, I was getting impatient with Joan, I tried to imagine what her audiologist might have been feeling. I decided to give him a call. He reported that indeed, 68-year-old Joan showed up on

time for her appointment with him, and answered his query, "Are you having problems with your hearing?" with "I want hearing aids." No problem, or so it seemed. He took a thorough history, explained the diagnostic and prescriptive procedures, and scheduled an appointment for a comprehensive audiometric evaluation. She showed up on time, dutifully nodded her head in apparent appreciation as he explained the audiogram and recommended hearing aids. "It was a good meeting," the audiologist told me. Reportedly, she thanked him for his time and assured him she would call the next day when she would have her appointment book handy. That was over 10 months ago.

Indeed, Joan had mollified her adult son by agreeing to the appointment that he had set up. She had succumbed to his onslaught of fairly traditional methods of coercion – blackmail ("I won't call you every Sunday anymore"), guilt ("Your grand daughter wants you to hear every word of her recital"), and finally outright begging ("Please, Mom, won't you...?"). But she got the last word. She gave her audiologist a version of "I'll see you around." A familiar finale for hearing care practitioners, I am told.

"So help me understand something," I continued. "Why have you continued to see me?" Today was our fourth appointment in a month's time. Her internist had referred her because of depression and family conflicts that had been exacerbated since her husband died three years ago.

"*Most of the time, you don't tell me what to do!*" came her immediate reply, with purposeful emphasis.

"Who else tells you what to do?" I knew the answer, but wanted to begin "flushing out" the interpersonal dynamics having to do with power and control.

"My son. Since he was a little boy, he has always wanted the last word. Now he's a hot shot attorney and thinks he knows what's best for me. Well he

doesn't! The other day, he left a copy of Hearing Loss [from SHHH - Self Help for the Hard-of-hearing] on the dining room table. You know what I did? I threw it out!" Joan displayed triumphant glee.

"So what do you think would happen between you and your son if you could hear better?" I asked.

"He would get smug and say 'I told you so.' And then we'd have a fight."

"And who would be the first to notice the fight?"

"My daughter, Janice."

"And what would Janice do?"

"She'd come to my defense and tell Mark [my son] to get off my back. She feels the way I do - since my husband died, Mark has tried to take his place."

"So from your point of view, getting hearing aids would increase Mark's know-it-all attitude, would give him more power, then lead to a fight between him and you, and then between him and his sister."

"Yeah."

"And how would it end?"

"Well, Janice's husband is also a lawyer and works in the same practice as Mark. He would talk to him."

"And then what?"

"Mark would calm down, but only until the next flare up."

Suddenly a complicated dance became visible! In a sense, Mark had accompanied Joan to her initial hearing appointment – not as a physical entity (he was invisible), but as a dominant psychological presence nonetheless. It is vital to determine the cast of characters who influence the treatment of a patient's hearing loss and who are, in turn, influenced by it. Although one individual may physically enter the office, as Joan did, indeed there are typically more phantom people in the room. And the interactions among these characters – their "dance" – is patterned over time, multi-layered and exert a powerful influence with respect to patient adherence to audiologic recommendations.

Circular questioning

One effective method of discovering the relevant cast of characters and of mapping their interactions around your prospective treatment plan is a family therapy technique called "circular questioning." (Palazzoli, Boscalo, Cecchin & Prata, 1980). It was developed by a group of Italian therapists to facilitate their work with highly "treatment resistant" schizophrenic and anorexic/bulimic patients. I was using this technique with Joan to elicit the patterns of relationships around her hearing loss. Table 1 outlines some circular questions that can be used by hearing care professionals.

Table 1: A sampling of circular questions:

- Who referred you and who knows about your appointment?
- Who is most concerned about your possible hearing loss? Second most? Third most?
- Which of the above persons would be most concerned if you did or did not get hearing aids? Second most? Third most?

- Given that you get/not get hearing aids, what would [person X, Y, Z] say or do to each other? How might that help or hinder you?
- Then what would [person X, Y, Z] do with you? Then what would you do with them? How would that affect you? Etc.

Circular questioning gives you a front row view of the family drama or dance *which inevitably comes to include you as the audiologist*. Once you are aware of the cast of characters who affect, and will be affected by the so-called "identified patient's" hearing loss, it is often important to physically invite them into the room. You are then able to better understand the relevant "who says/does what to whom" interactions surrounding your treatment plan, which can increase the probability of patient adherence. Using a sailing metaphor, you move into charted waters.

However, Joan wasn't initially sold on this idea. She compared Mark and Janice to the Arab-Israeli conflict. I joked that we should see how much it costs to rent Camp David, the setting where Jimmy Carter facilitated Egyptian President Anwar Sadat and Israeli Prime Minister Menachem Begin reaching an accord in 1978. It wouldn't be practical, we agreed. But after some discussion, she did agree to invite Mark and Janice for a meeting, provided that Janice's husband, Tom – the peacemaker – would also be present.

A week later the family members physically entered my office. After thanking them for coming and exchanging complaints about the Boston humidity and traffic, I began by asking how Joan's hearing loss affected each of them and how they imagined it affected her. We established some communication rules, such as talking clearly, sequentially (not over each other) and giving Joan time to track the conversation.

Predictably Mark began: "My mother should get hearing aids which I've offered to pay for. They'll help her hear better and there's no reason why she shouldn't

take advantage of the technology and..." He pontificated for several minutes while Janice clenched the arms of her chair.

"Excuse me," I abruptly cut him off, "but I'm wondering how your mother's hearing loss affects *you*?" Obviously he had his opening summation fully prepared, but we weren't in court.

"My mother isn't able to use the telephone, she's isolating herself, she can't participate in family conversations..." As he continued, Joan, Janice and her husband, Tom, looked away. Psychologically, Mark and I were the only two people left in the room.

"Hey where did everybody go?" I wondered aloud.

"Sorry, but we've heard this all before," Janice sighed.

"Of course, you can't know what your brother is feeling, but if you could read his mind, how do you think your mother's hearing loss affects him?" I asked. If you can't go in the front door, try the side door, I thought.

"I know he means well and I'm sure he's frustrated. It's frustrating for all of us." Janice shook her head and looked toward her husband who offered his hand.

"And for you?"

"My mother's a loving, giving person and never wants anything for herself," Janice replied. "She's aged a lot since our father died."

"It's hard to see you mother being left behind?" I asked.

Janice nodded and then cut to the bottom line: "I'm afraid she's going to die." She then glanced toward Mark, perhaps, I thought, to warn that his conflict

with Mom is killing her.

"And knowing your brother better than I do (we just met 5 minutes ago), how do you think he handles that fear or frustration?" A bit presumptuous on my part, I thought, but probably a safe bet.

"With verbiage!" Janice scowled. Her voice suddenly changed from empathic sadness to irritation. Almost on cue, Joan nodded her head and lunged forward in her seat. I could see where this was going.

"She doesn't have to be so frustrated," Mark grunted. "That's why I..."

"Excuse me, again," I said. "You're acting like my doctor who yelled at me that I need to lose weight. After my appointment with him, I had a candy bar! That showed him!" I wanted to set the stage for a later discussion on how to motivate people.

"So what are you asking me to do?" Now *he* looked irritated.

"Listen to the patient! You took the time and effort to arrange for your mother to get her hearing tested, but you ended up butting heads with her and then teams in your family got formed. The result is everyone loses. Would you ask your mother, kind of interview her, about how she deals with her frustration with hearing?" With that request, I instantly earned points with everyone except Mark.

Accordingly, he replied, "As I told you, she doesn't have to be so frustrated."

Perhaps I erred in sparring with him. Psychologists are prone to giving summations too, and the irony was that this time my topic was about listening to the patient! In the words of a family therapist mentor, Salvador Minuchin, I needed to "first stroke then kick," first establish rapport then confront. I would

try to recoup.

"Mark, on a scale of 1 to 10, with 10 being most frustrated and scared, where are you?"

"About an 11," he immediately replied. He paused and no one was about to break the silence. "It just hurts me to see her cut off from her family and friends," he finally said. His fear was palpable.

I nodded my head, as he gave us a glimpse into his world. Janice looked at him more compassionately and nodded her head.

"Eleven's a pretty high number. It hurts you and you love your mother so much and you've worked hard to help her. But the more active you become, the more passive she becomes, while at other times, you butt heads.

"We're alike in some ways; we're both stubborn." Finally Mark and his Mom let out a laugh, effectively providing a brief emotional respite.

Having connected better with Mark, maybe I could lead him to relate to Joan differently. "Mark, could we interview your mother together?" I asked. "Could you just be curious about how it feels to be in her shoes?"

He took a minute, perhaps to decide whether to dispense more information or to find out about his mother's internal world. Then perhaps from exhaustion or a realization, his face softened, he looked at his mother and asked her the simple question that both he and all the health care professionals had neglected to ask: "Mom, would you please tell me, tell us, how you feel not being able to hear well?"

"It's part of growing old," Joan quickly replied. She needed no time to ponder her response. It was obviously a question she has privately asked and answered

many times.

"It doesn't have to be. It —" Mark proclaimed, now falling back into his well-intentioned badgering.

"Hold on, please. Would you just be curious? Would you only ask questions and try to put words to how your mother feels, without trying to fix the problem so quickly? Would you ask her to say more about growing old, about what it means to her? Just listen and be curious." In my mind, psychologist Carol Gilligan entered the room:

"I approach people with a desire to learn from them or to discover with them what they know. How do you listen *when you want to discover another person's inner world, as opposed to figuring out where someone falls on your map of the world?* (my italics)... I strive for a kind of Zen-like innocence, where I work from a genuine position of not knowing...defined as something I'm genuinely curious about, so in that sense it's a real question, something I don't know the answer to." (Gilligan, 2002, p. 50)

It was time to end. I gave them a copy of the above quotation and we scheduled a time for the following week.

They appeared on time for our meeting and took their respective seats. Mark and Janice had lunch together several days prior and there was noticeably less tension between them. He playfully remarked that he would do his best to be curious, although he was quick to add, "I can't sit in a yoga position." I shrugged my shoulders in mock disappointment and said we'd proceed the best we could. After some coaxing, Mark did a nice job of asking questions and listening. Whereas he had up to now inadvertently infantilized his mother, now he allowed himself to learn from her – to honor her as his teacher. "Please tell us more" was his frequent refrain. Carol Gilligan was proudly nodding her

head.

In response to Mark's now authentic curiosity and concern, Joan made eye contact with him, and then did the same with her daughter and son-in-law. Then she shut her eyes and grimaced: "I feel like I'm being robbed!"

"Robbed of what, Mom?" a surprised Janice asked, now in consort with her brother.

"Robbed of my life, my body, who I am, that's what!" Her terror became flooded with anger and outrage. We fell silent. Now in a softer tone, Joan looked at her children and recounted a recent nightmare:

"Your father and I are driving to the Jersey shore which we love so much. We park the car and he goes to get some ice cream. But he doesn't come back. It gets dark and I'm sitting alone in the car. Then a gang of hoodlums comes. They have knives and are going to take everything I have and kill me."

"Your hearing loss is the gang who is going to rob you and kill you." I said. Terror is common experience for persons with adventitious hearing loss (Harvey, 2001, 1998).

"It's robbing me of who I am; it's killing me."

"Do you think you'll be with Dad?" Mark suddenly asked. I was taken aback by his question, seemingly out of nowhere, but Joan wasn't.

"I miss him so much, you have no idea, you don't know what it's like to lose someone that you've shared your life with for 50 years. You have no idea what it's like going to bed alone, waking up from a horrible nightmare alone, watching TV alone, eating ice cream alone..." Joan let out a long list and let her despair envelope the room.

Mark had asked the essential question that Joan perhaps was answering, albeit indirectly, but I wanted to be sure. "Mark, can you ask your Mom that question again?"

"Mom, you said losing your hearing is killing you. Is that what you want? Do you think if you die that you'll be with Dad?" Now tears came to his eyes. But Joan became calm, and with an eerie resignation, nodded her head.

Somebody had finally asked the key question. Her progressive hearing loss took her at knife point and would hopefully kill her, for only then would she reunite with her beloved husband whom she longed for so much. Hearing aids, she told us later, would engage her more in a world that was full of many wonderful people but not the person she yearned for the most.

An important principle: often family relational patterns need to shift before a family member's behavior can shift. I had assessed the patterns of Joan's family via circular questioning and found that Mark was essentially parenting his mother who responded with passive hostility, while Janice colluded with her mother against Mark. It was only when these conflicts lessened that Joan's depression became apparent: her resignation, withdrawal, wish to die and morbid dreams.

Joan's resistance to hearing amplification was seemingly a minor setback in contrast to these more affectively (emotionally) potent issues, but it kept her acoustically and conversationally isolated which, in turn, undoubtedly exacerbated her depression. I found myself ruminating about what the audiologist could have done.

It was about one year ago that she went through the motions of getting her

hearing tested to mollify her son. What if the audiologist had elicited and listened to her story instead of immediately commencing diagnostic and prescriptive procedures? What if he had the requisite training to use circular questioning and learned that there were several unknown phantom family members in the room? What if he had elicited and validated Joan's ambivalence about hearing aids?

On the one hand, the audiologist expertly diagnosed Joan's hearing loss and offered appropriate treatment, in consonance with his role and professional training. Clearly, it would have been unethical for him to have attempted to treat her depression, as he wasn't a psychotherapist. And he didn't want to open up a "can of worms" which he wasn't qualified to handle. Finally, he felt that his pressured schedule didn't permit him the luxury of listening to patients' stories. He deemed them as irrelevant to the task at hand and moreover, he knew from bitter experience that their stories may go "on and on." These were valid points.

My perspective as a psychologist is as follows: *Although he diagnosed her hearing loss, he missed an opportunity to facilitate appropriate treatment.* He compassionately *offered* and even *recommended* treatment but Joan rejected it. So what else could Joan's audiologist have done?

Enter *motivational interviewing*: a protocol for health-care professionals to assist people who are ambivalent about change, including patients who are resistant to using hearing aids (Harvey, in press). An important tenant of this approach is that patient motivation depends on the quality of interaction between the patient and provider which includes, but is *not* limited to, compassion and rapport:

"Motivation is not a general trait existing within ... an individual... but is an

important part of the counselor's task... [which is] not only to dispense advice but to motivate – to increase the likelihood that the client will follow the recommended course of action. From this perspective, it is no longer sensible for a therapist to blame a client for being unmotivated to change, anymore than a salesperson would blame a potential customer for being unmotivated to buy. Motivation is an inherent and central part of the professional's task." (Harvey, in press; Miller & Rollnick, 2002; Miller & Rollnick, 1991).

A caveat: dispensing verses selling

The above reference to "salesperson" deserves special mention. I am an outsider to the profession of audiology, but am aware of the discomfort around being perceived by the public as salespeople and that the notion of selling is unprofessional. Using the practice of medicine as an analogy, a physician does not "sell" antibiotics to a patient with pneumonia; s/he prescribes it. However, to continue with this analogy, note that the patient adherence rate for medical treatment is dismal, ranging from 5% to 50% — at best, a flip of a coin (Riekert & Drotar, 2000).

Like most health care providers, I became a psychologist to offer assistance, not to be a salesperson. But early in my career, I realized it's not that simple. As audiologist Sweetow (1999) noted, "Selling and counseling cannot be separated." Like it or not, we helping professionals do "sell" a product of sorts; we use psychological techniques to increase patients' motivation and adherence to a treatment regimen. But unlike some salespeople, we fervently and ethically believe that what we are offering or dispensing will, in fact, improve the quality of our patients' lives. The title of a book chapter written by audiologist Rennae Picket says it all: "How to sell hearing professionally" (Picket, 1999).

Motivational interviewing: My "what if" fantasy

I am certainly *not* blaming Joan's audiologist; he didn't have sufficient training with psychological techniques for managing ambivalence and increasing a patient's level of motivation. I recall when I first took a course on sexual abuse. It was just in the nick of time, I mused, because immediately after I finished the course, many of my patients began talking about issues of sexual abuse with me. Obviously, something else was going on. (I began asking questions about it). As helping professionals, the quality of how we relate to our patients is largely a function of our training.

What if we could move time backward to when Joan met her audiologist? The scenario might go something like this...

Joan arrives on time for the appointment. She and the audiologist exchange complaints about the Boston humidity and traffic. But when it comes time to end the introductory chit chat, he doesn't assume that Joan scheduled an audiology appointment because of concerns with her hearing. He simply asks, "How can I help?"

"I came for a hearing test and hearing aids," she politely replies.

"I see. [begins circular questioning]. Would you tell me who referred you or knows that you came for a hearing test?"

"My son," she replies.

"Tell me about your son."

"Well, he's Mr. Know-it-all, and has been badgering me to get hearing aids for years."

"I see (smiles). Who else is concerned about a possible hearing loss?"

"My daughter Janice and her husband, Tom."

"And which of them – Mark, Janice, or Tom – would be most concerned if you did or did not get hearing aids?"

"Definitely Mark. Janice and Tom are more compassionate. They would understand that it's my decision."

"I see. And what would they do?" the audiologist asks, with authentic curiosity.

"Mark would get angry and scold me. Janice would come to my defense, and they would fight. Then eventually Tom would break it up."

"Whew. And how would all that affect you?"

"I want no part of it. I want out of this family. Mark can take his hearing aids and... And frankly, since my husband died, life's not worth living anymore."

A short pause. "It feels very bleak to you, I bet. Lot of emotions and people involved."

Joan nods her head.

"So we may not want to go full force toward fitting you with hearing aids. But would it be okay if we maybe talk for a bit about your concerns and go ahead and test your hearing, but hold off on treatment until I understand more how it would fit into your life and family issues?"

"Absolutely!" Joan responds appreciatively.

The audiologist takes a history, tests her hearing and determines that she has a bilateral, severe to profound, downward sloping, high frequency hearing loss.

Having gleaned a sense of the family dynamics via circular questioning, he now focuses on assessing and increasing Joan's level of motivation for treatment. The audiologist uses techniques from motivational interviewing of eliciting four categories of self-motivational statements, also called "change talk" (Miller and Rollnick (2002):

1. Problem Recognition

- "Why did you believe you had a hearing loss prior to coming here?"
- "What difficulties have you had in relation to your hearing loss?"
- "In what ways do you think you, or other people have been affected by your hearing loss?"
- "How has your hearing loss stopped you from doing what you want to do?"

2. Concern

- "What worries you about your hearing loss? What can you imagine happening to you?"
- "How do you feel about your hearing loss?"
- "How much does that concern you?"
- "What do you think will happen if you don't get hearing aids?"

3. Stated intention to change

- "What makes you think that you may need to get hearing aids?"
- "If you were 100% successful and things worked out exactly as you would like, what would be different?"

- "Do you remember a time when your hearing was better? What has changed?"
- "How has your hearing loss stopped you from moving forward, from doing what's most important in your life?"

4. Degree of self-efficacy to change

- "What encourages you that you can get hearing aids if you want to?"
- "What might stand in your way of getting hearing aids?"
- "What are the options for you now? What could you do?"
- "What would be the best results you could imagine if you got hearing aids?"

The audiologist wisely assumes that Joan, like most patients, is ambivalent about hearing amplification and he therefore respectfully makes her ambivalence part of the *collaborative* dialogue. (Although Freud was incorrect about penis envy, he was right when he noted that every decision is characterized by ambivalence). Accordingly, the audiologist says, "I believe hearing aids will help, but undoubtedly, there are many pros and cons..." He helped Joan fill out a *decisional balance sheet*, as exemplified in Table 2 – a tool to help Joan amplify (pun intended) both sides of her ambivalence; the pros and cons about change versus no change, hearing aids versus no hearing aids.

Table 2: Decisional Balance Sheet for Joan

	Use hearing aids	Do not use hearing aids
Costs	<ol style="list-style-type: none"> 1. Mark might say "I told you so." 2. Mark and Janice would fight. 3. Abandoning deceased husband. 	<ol style="list-style-type: none"> 1. Miss out with grandchildren. 2. Not hearing movies. 3. Will miss out with TV & music.
Benefits	<ol style="list-style-type: none"> 1. More involvement with family. 2. More enjoyable listening opportunities, i.e., music, telephone. 3. Less fatigue and anxiety hearing. 	<ol style="list-style-type: none"> 1. Finally get last word with Mark. 2. Will be with Alex again [deceased husband] 3. Avoid stigma of looking old.

Now her binary, yes-no decision to purchase hearing aids becomes visibly more complicated than it first appeared. And since the complexity is "on the table," the audiologist can directly affirm and validate Joan's ambivalence – operationalized as her balancing the quadrants having to do with the costs of no aids/benefits of aids verses the benefits of no aids/costs of aids.

There are many options at this point. Joan and the audiologist may agree to invite some family members for a meeting since, as it stands now, one of Joan's reasons *not* to use hearing aids is that Mark would gain "I told you so" power. Much like diplomats do with warring factions, he could help Joan find ways to save face with her son, yet essentially follow his advice. I recall a similar instance when an oppositional father finally agreed with his adult son to purchase hearing aids, but only with the stipulation that he wear his aids on odd-numbered days. There are many creative possibilities.

Having established a solid connection with Joan, the audiologist can initiate a referral to a psychotherapist. Joan is obviously depressed, perhaps even suicidal.

Here it is often useful to frame the reason for the referral as educational, that

is, as a way to learn more coping skills with hearing loss – not as reflective of emotional disturbance.

But most importantly, the audiologist realizes that empathic or reflective listening is *not* a luxury. It is the fertile soil in which the seeds of direct intervention strategies are planted. Perhaps he read English's (2003) initial investigation of doctoral student audiologists who have incorporated counseling skills into their practice:

"Most of the students concerned about time restraints later found that with practice and reflection, they had developed techniques which did not require additional time. In fact, many student reported that, because they 'followed the patient's lead,' they actually saved time." (p. 3).

To listen or not to listen; that is the question

Then why is listening to patients not commonplace? One audiologist noted lack of training and hurried appointments:

"When I first started fitting hearing aids, my first reaction was to 'fix' the problem by manipulating the output or a trimpot. I think in school we aren't taught to really listen to the patient and troubleshoot from all angles. The realization that the aid isn't always the problem took a little experience. If we ask a few questions first and get the whole picture we get so much more information. We live in a hurried world of appointments and schedules and we try to address what we think are problems instead of really listening to the patient."

Another audiologist alluded to her comfort level with objective interventions versus more amorphous compassion:

"Quite frankly, I never thought that people with hearing loss experience such deep suffering or torment. I always thought that by listening to patients for twenty minutes and imposing a solution such as a hearing aid on them was all I needed to do. I don't think I was able to fully understand them... But I am not certain of how to apply these ideas to my practice other than bringing forth greater compassion and understanding."

Confusion with mental health counseling has also been noted:

"I'm not convinced we should be significantly involved in the counseling process beyond the informational level. I think part of being a good audiologist is recognizing when an individual with hearing loss and/or family member is having a tough time dealing with, coping with and accepting the hearing loss and making an appropriate referral to a psychotherapist who is trained to deal with these issues. You can only wear so many hats and we shouldn't beat ourselves up if we can't solve all of a given patient's problems."

Then there is the thorny issue of payment, as noted by Pessis (2003):

"Traditionally, counseling has been bundled into the cost of the hearing aid. Since hearing aids are usually not a covered benefit under most insurance plans, the cost of counseling can be itemized as a separately identifiable service and billed directly to the patient.

"When hearing aids are covered by insurance, it is unlikely that separating-out the cost of counseling will be reimbursed. One may try billing for CPT codes 92590 (monaural hearing aid) or 92591 (binaural hearing aids) along with "hearing aid exam and selection." Medicare will not reimburse for these codes. Likewise, aural rehab has not been reimbursable to audiologists for hearing aids since it is a treatment code. There is a movement at the national level to create new CPT codes to address this deficit. This takes years.

"In short, there is no reason that the audiologist cannot bill for aural rehab/counseling, but, the patient needs to understand that this is a non-covered benefit by third party payers. If you do choose to bill separately, I would recommend that you have the patient sign a waiver acknowledging that it is a non-covered benefit. It is wrong to conclude that because third party payers don't pay for this service, that it shouldn't be billed. AR/counseling is time-consuming, but is a necessary component for effective hearing health care."

I am not an audiologist; I wouldn't know CPT code 92590 if it hit me on the head. But note my earlier error of not sufficiently listening to Joan and then Mark – and I get direct reimbursement for listening! As I look back and do a "psychological autopsy," I realize that my self-esteem was too involved. I wanted to make clever interventions, hopefully catalyzing Mark to discard his pedantics posthaste, just like what happens on television where the protagonist solves multi-layered, complex problems just before the last commercial.

The decisional matrix depicting ambivalence about listening may look like this:

Table 3: Decisional Balance Sheet for audiologists

	Listening with curiosity	Prescribing/fixing problems
Costs	<ol style="list-style-type: none"> 1. Tough to bill for it. 2. May vicariously feel pts' grief and pain. 3. Stories may seem redundant. 4. Blurs boundaries with psychotherapy. 5. Pt may go on and on. 	<ol style="list-style-type: none"> 1. Less pt adherence. 2. Pt often disappointed. 3. More returned hearing aids. 4. More unmet pt expectations. 5. Deprives providers of wisdom from pt's stories.
Benefits	<ol style="list-style-type: none"> 1. Increases pt's motivation. 2. Less hearing aid returns. 3. Better rapport; pt gains emotional benefits from mtng. 4. Provider gains wisdom. 5. Better pt adherence & prof. satisfaction. 	<ol style="list-style-type: none"> 1. Dx/Rx is what we're trained to do. 2. Pt wants problem solved. 3. Better/easier reimbursement. 4. Works in crisis. 5. Provider feels useful/worthy.

Of course, we cannot know what would have happened if Joan's audiologist had been able to elicit the family dynamics via circular questioning and her ambivalence via motivational interviewing. Indeed, without adequate training, he could have opened up a "Pandora's box" – an outcome that must be avoided at all costs. Or perhaps Joan might have simply thanked him for his time, assured him she would call the next day, only to never return.

One thing is for certain; bearing witness to a patient's story also benefits providers. One audiologist described her profession as giving her life more *contrast* and *texture*:

"We have the experience of knowing intimately people we would otherwise not have known, and of sharing vicariously in others' life choices and struggles, their most intimate feelings, needs, and concerns which get sparked by their loss of hearing. Our connections with clients through humor, love, and pain contribute enormously to our growth as individuals, add complexity to our lives, and increase our capacity for empathy and understanding.

"At times we have had glimmers of wisdom resulting from our work. Our clients teach us the things we might have learned from grandparents, wise elders. Sharing joy and sorrow, laughter and pain, wisdom and ideas with another person is at the heart of what it means to be human."

Joan gave me a safe glimpse of the dangers of loss, the psychological "land mines," and the wisdom to know there are no simple answers or prescriptions. It was only when her family and I learned of the psychological symbolism that Joan ascribed to hearing aids – that hearing aids would thrust her into the world of the living - that she wanted no part of – that positive change occurred. Her family relationships began to shift, in that Mark and Janice had been visiting more often and fighting less, and Tom happily gave up his job as

peacemaker. These changes, in turn, set the stage for her internal emotional growth.

Joan and I met for eight more visits and discussed her depression, protracted grieving for the loss of her husband, hearing loss, and possible reasons for living as opposed to waiting to die. Her internist prescribed an anti-depressant. Treatment was going well. One day she arrived at my office looking unusually pleased with herself. Unbeknownst to me (and to Mark), she had made an appointment with another audiologist – this time one that she had found in the Yellow Pages! As before, she showed up on time for her initial appointment. But unlike before, the audiologist broke the barriers of a typical diagnostic/treatment session. After beginning by simply asking, "How can I help?" he asked Joan about herself, her inner world, her family, and elicited self-motivational statements having to do with hearing amplification. Perhaps he had received additional psychological training or had an intuitive grasp of relational dynamics. But the benefits of his approach were not lost on Joan. "He wanted to know about me and listened to what I said," she exclaimed. "He asked me how I felt about losing my hearing." Joan then paused and said matter of factly, "When I see him next week, I'll ask him about hearing aids."

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