

IMPORTANCE OF MOTIVATIONAL INTERVIEWING THERAPEUTIC  
TECHNIQUES IN AUDIOLOGY CLINICAL WORK

Capstone Project

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## ABSTRACT

Hearing loss affects individuals, not just in a physical manner but in an emotional one. The beginning of a sensory loss is a form of psychological trauma that may cause shock and confusion. These emotional and psychological changes may create a reduced quality of life and increased social isolation. Individuals who are learning about their particular hearing loss or using hearing aids for the first time are likely to go through various emotions, which may include embarrassment, frustration, anxiety, depression, or fatigue which may affect how they interact socially. It is important that audiologists understand the necessity of counseling for individuals, as they are most likely going through new emotions and are not sure how best to cope with their new situation. Clinicians do not have training with therapeutic techniques and counseling strategies, and a minimum of a broad understanding of therapeutic techniques would help to provide clients with the best possible outcomes for reducing the negative impact of their hearing impairments.

## DEDICATION

This document is dedicated first and foremost to God in whom all things are possible for providing me with the strength and courage necessary to achieve a doctorate. It is also dedicated to my late grandfather who decided to obtain multiple medical opinions on treatments for his hearing loss and who never pursued hearing aids. With some supportive counseling from an audiologist, he may have found the process to be less burdensome and more rewarding. Lastly, this document is dedicated to my family, friends and fourth year externship supervisors for their unfailing love and encouragement.

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## **CHAPTER 1**

### **INTRODUCTION**

How a hearing loss affects an individual mentally, emotionally, and psychologically is often overlooked. Many clinicians simply test and evaluate the client's hearing loss and try to alleviate the impairment by fitting a hearing aid and manipulating the gain settings and adaptive features to make the client more comfortable. A significant portion of the effect of hearing loss is not just physical - it is emotional. Clinicians have extensive training in the science behind audiology but may not have training for many therapeutic techniques and counseling strategies. These are often learned through experience with each individual client, as each client has various needs and hopes; however, a minimum of a broad understanding of therapeutic techniques would help to provide clients with the best possible outcomes for reducing the negative impact of their hearing impairments.

Individuals with hearing loss are affected in many ways. Fellingner, Holzinger, Gerich and Goldberg (2007) stated that individuals with hearing loss have much poorer social relationships than those with normal hearing. But the problem is not simply one of hearing loss, as hearing impaired individuals also had poorer social relationships than those who are deaf. Heine and Browning (2002) discuss how people with poor sensory

acuity (hearing loss, vision loss, etc.) feel isolated and limited, lonely, vulnerable, exhausted, depressed, frustrated, annoyed and embarrassed. They are less secure, less self-confident, have poorer self-esteem and have more adjustment issues compared with individuals without poor sensory acuity. Wood (1987) indicated that the beginning of a sensory loss is in fact a form of psychological trauma that may cause shock and confusion. These emotional and psychological changes may create a reduced quality of life and increased social isolation (Heine & Browning, 2002). Many individuals with hearing loss go through emotional changes, and they may go through cycles of functioning in a way that an individual seeking therapy in other aspects of his/her life may. Additionally, Oppegard, Hansson, Morgan, Indart, Crutcher & Hampton (1984) explained that sensory loss is related to anxiety and depression in those who do not have good social and caregiving support. Sensory loss, along with a lack of social interaction, pressures the independence of individuals with hearing loss, which can result in social and emotional concerns (Heine & Browning, 2002).

It is important to understand how individuals with hearing impairment initially seek help when they are having difficulty with their hearing loss. Oftentimes, they will need assistance in making the decision to seek help, and this relates to the need for counseling and the selection of the best counseling approach to use. According to Knudsen, Oberg, Nielsen, Naylor & Kramer (2010), the psychological journey of each individual with hearing loss when pursuing help has an influence on his/her choice to use a hearing aid and actually enjoy it. There are many ways this person will gain support throughout his/her journey, and these may include supportive counseling from an audiologist; discussing the opinions of hearing amplification devices from current users



and researching on one's own without support from others (Knudsen et al, 2010).

Seeking help and obtaining support from a knowledgeable audiologist who has a counseling background can have lasting effects on whether or not the client will be able to overcome the psychological factors involved with hearing loss. Knudsen et al. (2010) summarized studies specific to how an individual's attitude toward hearing loss affects the acceptance and coping with hearing loss. Garstecki and Erler (1998) found that adult males who did not think their hearing loss was stigmatizing and who were able to accept their hearing loss obtained hearing amplification more than those who felt the opposite way as demonstrated by the Communication Profile for the Hearing Impaired. Humes, Wilson and Humes (2003) indicated that individuals who had less stress concerning their hearing loss and greater self-acceptance of their hearing loss were able to acquire hearing amplification more easily than those who had less self-acceptance and more stress. Cox, Alexander and Gray (2005) revealed that those who seek hearing healthcare and obtain hearing aids show lower neuroticism scores. Since neuroticism is a long-term tendency to be in a negative emotional state, having lower neuroticism scores likely help individuals to cope with negative aspects of their life in more positive ways. With a positive outlook, the acceptance of hearing aids is easier.

It is not often understood how an individual's spouse/partner is affected by one's hearing loss, as audiologists do not always have the privilege of working with family members. The presence of stress in a relationship has an impact on the opinion of the severity of the hearing loss by both members (Preminger & Meeks, 2010). When an individual's mood is anxious or angry, he/she is more likely to have a poorer perception of the hearing loss. The measurement of one's mood is correlated with the psychosocial

rewards of counseling (Preminger & Meeks, 2010). Therefore, it is important that audiologists have the skills and experience necessary to counsel and provide aural rehabilitation to their clients. Hearing loss is not just a physical change in one's body but contributes emotional and psychological changes, as well.

Aural rehabilitation in the form of various therapeutic techniques has benefits, such as more effective use of hearing amplification, faster adjustment to hearing amplification, better communication skills, better understanding of speech in noise, more self-confidence and less social activity limitations (Henderson-Sabes & Bingea, 2014). Another reason aural rehabilitation helps clinicians is to lessen the hearing aid returns and follow-up appointments to the clinic (Henderson-Sabes & Bingea, 2014). There are many studies that have shown the benefits of various counseling.

Kemker and Holmes (2004) provided counseling to two different groups: one group received the counseling one week before being fit with a hearing aid and one group received the counseling both before and after being fit with a hearing aid. The counseling occurring prior to being fit with a hearing resulted in much higher levels of satisfaction when measured five weeks after the fitting. Cherry and Rubinstein (1994) implemented a telephone counseling program in which a counselor called the client 6, 9 and 12 weeks after he/she was fit with a hearing aid to ensure he/she understood to go to the clinic to have issues and concerns resolved as needed. This program showed a decrease in perceived participation restriction when measured 16 weeks after the hearing aid fitting.

Preminger (2003) assessed if the presence of significant others in group aural rehabilitation classes reduced the client's hearing handicap greater than what was reduced by attending the class alone. Subjects included 25 hearing impaired adults and their

significant others. The aural rehabilitation classes were an hour and a half in length and occurred during six weeks. The class titles included A Model of Communication, Repair and Facilitative Strategies, Hearing Anatomy and the Audiogram, Hearing Aids, Assistive Devices, and Speaking Clearly for the Hearing Impaired. Each class contained training in use of communication strategies, auditory perception and auditory and visual perception. Preminger found that there were greater improvements in hearing handicap when the significant other was present in the classes along with the hearing impaired individual. However, the significant other did not indicate as much improvement in hearing handicap as the client did. This study showed that it may benefit the client to have his/her significant other learn about the hearing loss and learn from other families who are experiencing the same things.

In a later study by Preminger & Meeks (2010), a correlational analysis was performed on data from 52 couples in which one member of each couple had hearing loss. The independent variables were hearing loss related quality of life scores measured in those with hearing loss, in their significant others and differences in hearing loss related quality of life among both members. The researchers found that in both members, perceptions of hearing loss related quality of life is highly correlated with negative mood scores. They explain that psychosocial characteristics have an influence on both the hearing impaired individual's hearing related quality of life and the significant other's. The authors offer three possibilities to these findings: increased negative affect in both members caused them to report reduced hearing loss-related quality of life, the problems that come along with hearing loss resulted in a negative outlook in life in both members, and that a possible third factor may have mediated the relationship between mood scores

and hearing handicap scores. These psychosocial characteristics can be changed or modified by aural rehabilitation in the form of counseling with various therapeutic techniques.

Anderson and Noble (2005) and Scarinci, Worrall & Hickson (2008) investigated attitudes about hearing loss and how these may affect treatment outcomes. Anderson and Noble (2005) indicated that when people with hearing loss thought their hearing loss was more severe than what their partner believed it was, both members were more satisfied with their relationship. Also, when those with hearing loss acknowledged their hearing difficulties and took responsibility for implementing communication strategies into their daily lives, happier relationships ensued. Scarinci et al. (2008) found that when the individual with hearing loss accepts his/her hearing loss, it has less of an effect on the significant other.

Motivational interviewing is a positive way to provide counseling, and there are specific therapeutic techniques that can be applied with the client. Therefore, it may benefit audiologists to have expertise, or at least familiarity, with motivational interviewing in order to maximize the benefit the client derives from the limited amount of counseling time they will have with the audiologist. This, in turn, will allow the audiologist and client to maximize the benefit from the audiologic rehabilitation being employed. The purpose of the following review is to introduce motivational interviewing techniques, and provide examples of how it might be used in an audiologic setting.

## **CHAPTER 2**

### **Motivational Interviewing**

Audiology education includes diagnostic and prescriptive tools for hearing aid fittings; however, it does not typically include practice in developing the psychological tools to use when a particular client is not willing to change or willing to pursue amplification (Harvey, 2008). Examples of these tools and techniques will be discussed in Chapter 4. In order to be successful, clients often have to experience two psychological processes, which include grief and the acceptance of change (Kooser, 2014). Clients actually experience a change in self-identity and must make behavioral changes. Motivation must come from within the client so that he/she can take ownership of the problem of hearing loss (Kooser, 2014).

Motivational interviewing is a directive approach that works to enhance the client's motivation to change by resolving the client's ambivalence with a specific goal to help him/her make positive behavioral changes (Teater, 2010). Motivational interviewing was proposed as a substitute model for direct persuasion (Wahab, 2005). It emerged as a treatment plan as an alternative to confrontation. It was originally designed for motivating clients to recover from drug use, as these people are resistant to ceasing drug use (Harvey, 2008). In motivational interviewing, the clinician's job is to increase

the positive aspects to making a change, rather than focusing on the negative aspects of maintaining the status quo (Teater, 2010). The counseling clinician listens as the client explains his/her desires, abilities, reasons and needs, and then the clinician repeats these back so that the client can understand his/her own reasons for making a change. Clinicians ask questions to discover the client's implicit needs and how they were developed in order to transform them into explicit needs (Harvey, 2008). They avoid using de-personalizing labels, use empathy more than authority, center treatment on the client and respect the client's decisions (Teater, 2010).

By using various techniques, the clinician who is acting as a motivational interviewer ensures that the client has the three aspects of motivation that include: importance to make a change so that he/she desires to make a change, confidence in the ability to make a change, and readiness to make a change (Teater, 2010). All of the various jobs of the clinician are conducted using a specific communication style and interpersonal skills (Teater, 2010). Motivational interviewing has to be done in a supportive, and non-judgmental environment so that the client feels free to explore his/her motivations (Wahab, 2005). The client goes through multiple stages of change, which include precontemplation or denying that there is a problem; contemplation, when the client is unsure about change; determination, when the client actually seeks help to change; action, when the client accepts treatment; maintenance, or strategies for the client to maintain the changes he/she has made; and relapse, which are strategies to prevent going backward (Harvey, 2008). This is a client-centered practice, and the counselor must be empathetic and show unconditional positive regard for the client to feel strong enough to effectively make the change (Teater, 2010). The client needs to feel as if

he/she is the one who is making the change and that he/she is validated in the feelings that he/she is experiencing. This will help the client to see that he/she is the expert on his/her own life, and nobody else has the same understanding or ability to enact change. Clinicians need to have a mutual understanding of the client's emotions and thoughts about the world (Wahab, 2005). Readiness to change is usually not a characteristic that the client has initially when the diagnosis and need for treatment arises, but it develops as a result of the interpersonal interaction of the counselor and the client.

There are multiple parts of the motivational interviewing process that audiologists need to understand. The principles of motivational interviewing include: expressing empathy, developing discrepancy, rolling with resistance and supporting self-efficacy (Teater, 2010; Wahab, 2005). The client's potential ambivalence is resolved by showing the client his/her inconsistencies in the statements and goals stated. The clients' attention is focused on the differences between where he/she is and where he/she wants to be. There are four techniques that can be used during the motivational interviewing process, and they include: using open-ended questions, using affirmations, reflecting the client's feelings, and summarizing the client's statements. Change talk is language used by the client revealing his/her readiness to change. Examples of change talk include: "I wish..." "I think I could..." "I know I would feel better if..." "I should do this..." and "I plan to..." When clinicians encourage change talk, it provides a way for the counselor to show the client that he/she has the ability to make the change. Change talk is usually seen in one of four categories: disadvantages of the status quo, advantages of change, optimism for change and intention to change (Teater, 2010). It is important that clinicians understand how to use change talk, as it can bring forth ambivalence if used

improperly or reinforce change if used advantageously (Kooser, 2014). For example, when scaling questions are used, instead of asking why the client chose a smaller number and not a higher one, the clinician should ask why the client chose a higher one, rather than a smaller one even if it is lower on the scale (Kooser, 2014). In this example, by focusing on how high the number is rather than how low, the client is more likely to spend time thinking about what he/she has done successfully that has helped him/her to come thus far through change, rather than focusing on what is still in his/her way of changing. For the final element of motivational interviewing, there are techniques to increase the client's motivation to change, which include: scaling, decisional balance and looking back/looking forward (Teater, 2010). Decisional balance is weighing the pros and cons of the problem and the positive change, and it is helpful if this is written out for the client to see.

The ultimate goal of motivational interviewing is that the client develops a plan of how to make a positive change. The motivation to change is created and then a goal for the client to meet is created. This plan should address the end goals, specific tasks to be completed, tips, techniques and strategies that need to be implemented in order to prevent a relapse and if/when a relapse occurs. The plan should be specific, measurable, attainable, realistic and timely (Teater, 2010). Both the client and the clinician need to agree on the goals that are set. This goal needs to come from the current experience of the problem. There are four mechanisms of how goals should affect performance: direct attention and effort toward goal-relevant activities and away from goal-irrelevant activities; energizing function, or the higher the goals are, greater efforts are necessary in order to complete the task; persistence; and action, indirectly, by leading to the discovery



and use of task-relevant strategies (Greene & Lee, 2011). The goal needs to focus on what can be done, as opposed to what cannot be done. The more specific and easier to accomplish a goal is, the more the goal is likely to be achieved. The goals should be described in concrete behaviors. The goals should be useful, interpersonal, new and regular (Greene & Lee, 2011). For general motivational interviewing, examples of goal list topics include: benefits of status quo, costs of status quo, potential costs of change and potential benefits of change (Kooser, 2014). For hearing aid counseling, the client can list the pros and cons of hearing loss and hearing aids, a technique that is much like a standard validation measure after hearing aids are fit. This allows the client to identify any ambivalence present and to understand the possibilities of change.

Lastly, it is important to co-construct a collaborative therapeutic relationship with clients. This means that both the clinician and client offer input on the plan of action to make a positive change through counseling. There are multiple elements involved in developing and maintaining a collaborative therapeutic relationship with clients, and these include: being empathetic, taking a non-expert position, being nonjudgmental and accepting, using the client's language, taking a position of curiosity, and identifying/amplifying to the client on his/her successes and strengths (Greene & Lee, 2011).

## **CHAPTER 3**

### **Therapies that Use Aspects of Motivational Interviewing**

Both narrative therapy and Solution Focused Therapy (SFT) use motivational interviewing techniques. Some of these techniques will be discussed in Chapter 4. Some core tenets of both of these techniques are social constructionism, post-modernism, and the role of power and privilege. Social constructionism is the idea “that the beliefs, values, customs, labels, laws, and divisions of labor that make up our social realities are constructed by the members of a culture as they interact with one another from generation to generation and day to day” (Freedman & Combs, 1996, p. 16). This means that stories of the dominant culture are imposed on those of smaller cultures. Post-modernism is a belief that realities are socially constructed through language and are organized and maintained through narratives. It believes that there are no essential truths or objective reality, and meaning is more important than facts and rules. The idea of the role of power and privilege is that the clinician is available to change the system instead of some outside force, and socio-cultural-political climates have an influence on the client’s presenting problem (Freedman & Combs, 1996). The clinician can address these issues with questions such as, “What view does your faith community have about depression?” and “What role does being a woman play with depression?”

## **Narrative Therapy**

Narrative therapy is based upon the client's personal narrative and social construction, rather than family dynamics and conflict. One's memory uses a narrative truth, which is more important than historical truth, as this is the basis for which he/she lives his/her life. It is believed that clients are so used to their self-defeating cognitions, which are the stories in which people tell themselves about their problems. They are stuck in a one sided mindset in which they do not have room to make more optimistic ideas about themselves (Nichols, 2009). Narrative therapy seeks to alter the narrative to one that is directed toward change.

Clinicians using narrative therapy use three stages to their strategies: externalizing the problem and focusing on its effects rather than its causes, helping the client to see exceptions over the presenting problem and when they overcame it, and having the client find a supportive audience in which to help them make a lasting change (Nichols, 2009). Some clients may spend most of their lives believing that they themselves are the cause of their problems. Many clients have had this problem for so long that they begin to see themselves as being the problem, as if they are dysfunctional and defective (Greene & Lee, 2011). Narrative therapy helps them to externalize these thoughts so that they no longer have the idea that they are the problem but that their problems are their problems (Freedman & Combs, 1996). The clinician's job is to make note of the problem as an object outside of the client (Greene & Lee, 2011). This will help the individual client to begin to define his/her problems as separate from his/her identity (Carr, 1998). For example, instead of saying, "your depression," when the client says, "my depression," the clinician would just say, "depression" in order to externalize it

from the client and make it something separate from the client. The client will hopefully see that the clinician is being non-judgmental and accepting, while also being curious. Externalizing the problem allows the client and clinician to form a collaborative relationship to come up with ways to overcome the problem (Greene & Lee, 2011). The client feels at ease because the focus of change is on the problem, rather than on the client. The client will not feel that he/she has to defend himself/herself to the clinician but will try to control the problem by resisting the influence the problem has on his/her life. The client can form a different position toward the problem, rather than seeing the problem as enormous and unchangeable. When the clinician assumes the problem and the person are separate, the client can begin to externalize the problem and internalize personal agency (Carr, 1998).

Effects questions, landscape of action questions and landscape of meaning questions are important to narrative therapy. Effects questions work to map how the problem influences different aspects of the client's life and vice versa (Greene & Lee, 2011). The client is asked to map out the influence of the problem on his/her life and relationships, and then to map how he/she influences the problem (Carr, 1998). These questions explore what would happen if the problem was separate from the client and allows the client to examine how his/her relationships would change (Freedman & Combs, 1996). This is important because some clinicians may focus solely on how the problem influences the client's life but not on how the client can influence and change the problem. Separating the problem from the client shows the client that the problem is not in control, but the client is, as the client is not the problem, but a person who has a relationship with the problem (Carr, 1998). Landscape of action questions ask when the

client was able to resist the effects of the problem. These questions refer to the aspects of the client's life that run counter to the narrative that is dominated by the problem. Many of these questions begin with who, what, where and when. Landscape of meaning questions build upon the landscape of action questions. Once the landscape of action questions have established to the client that they are many aspects of his/her life that are not consistent with the negative aspects of the narrative, the landscape of meaning questions help the client to consider a new view of the self and to make new meanings of his/her story (Freedman & Combs, 1996) by asking the client what the different aspects of the narrative tells the client about himself/herself.

The concepts of unique outcomes and reframing are also key concepts in narrative therapy (Nichols, 2009). Unique outcomes are built upon times in the past when the client has acted free of his/her problems, even if he/she was unaware of doing so (Nichols, 2009). These reflections help the client to understand that his/her life is not dominated only by the negative and that the client has the ability to change his/her mindset. They challenge the client's negative presenting problems to make room for hope. They help the client to find unique outcomes in which to create more positive stories so that he/she may believe in himself/herself and become the authors of his/her own life. Clients often focus on their problem-saturated story, which is their narrative constructed by emphasizing problematic experiences and ignoring their unique outcomes (Freedman & Combs, 1996). It is important that clients have audiences of support that will help them to progress with the change in their mindset.

Reframing involves the clinician aiding the client in creating more positive outlooks on his/her presenting problems so that he/she can change the beliefs from which

negative stories arise (Nichols, 2009). The options that individuals perceive themselves as having can be affected by how they use language to label their experience of reality in order to make sense of the world (Greene & Lee, 2011). These specific perceptions of reality are called frames. These frames are created by one's assumptions, knowledge, beliefs, and experiences. Frames can be thought of as smaller narratives that make up the more complex narrative of a person's life. In the context of narrative therapy, a frame can be thought of as how the client sees the problem. These frames shape the way the client perceives and acts in his/her world. These frames create the expectations for how he/she should behave and how the problem should be solved (Greene & Lee, 2011). A hearing impaired individual's quality of life is not only influenced by the hearing loss but by the individual's frame of reference (Preminger & Meeks, 2010). When individuals have limited frames of reference about their individual problems, they do not have flexibility in dealing with problems, as their perception of the world beyond their problems is too limited (Greene & Lee, 2011). When they deal with problems, they conduct themselves in limited and predictable ways (Greene & Lee, 2011). In social interaction, frames are co-created out of what the sender and receiver contribute to the conversation (Greene & Lee, 2011). An example of a frame between spouses is a client who believes he is a person with hearing loss who is unable to connect with the people in his life in a way that is positive. He only sees all of the bad aspects of his life with his wife, since most of their interactions are negative. When good things do happen, he often forgets them because they do not fit into his current frame or state of mind. He views his hearing loss as himself, rather than as a problem that he can work to change for the better. His wife has a similar frame and idea that her husband is unable to connect with her and

her friends due to the hearing loss. She has not experienced a time when her husband was truly enjoying himself around her friends, and she does not think this is possible due to her current frame or state of mind. This is further discussed in Chapter 4.

Frames are reinforced through a number of actions, which include: showing excitement in what the sender is saying if it fits in the desired frame, asking questions and telling stories that are consistent with the desired frame, and connecting different ideas so that they are consistent with the desired frame (Greene & Lee, 2011). Clinicians using motivational interviewing with narrative therapy encourage the clients' friends and family to witness the clients' new self-narrative and ask the client, "Who would notice the steps you have taken, and what would that person notice?" (Freedman & Combs, 1996).

Reframing is the "deliberate manipulation of information that clients use to ascribe meaning to thoughts, feelings, behavior, or situations" (Jones, 1986). The act of reframing helps the client to broaden the possibilities and options he/she has, as the clinician offers an alternative meaning to the current facts the client has about his/her situation (Greene & Lee, 2011). A frame will not be acceptable to the receiver if it is not consistent with his/her assumptions of the world. The positive reframe has to be an idea that is acceptable and meaningful to the client. The clinician needs to work to learn the client's frame and then give ideas that can become associated with the frame that may work to expand it. The clinician works to provide a positive meaning to something that the client has been viewing negatively, such as the hearing impairment. An attempt is made to change what the client perceives as deficit in himself/herself into an attribute the client can see as as a strength or resource he/she has. If a client solely focuses on the

problem behaviors that he/she has, the problem will seem overwhelming, as if there is nothing that can be done to change the situation, but if positives are emphasized, the solution will seem closer than previously thought (Greene & Lee, 2011). The attributes that the client believes do not themselves change, but the meaning associated with them does change, and this allows the client to have a broadened sense of reality with a greater number of alternatives. Clients find the act of reframing to be helpful because upon receipt of the new frame, they can no longer live a narrow-minded lifestyle, as they have access to new ideas and strengths. Even if the client believes the new frame is not plausible upon first hearing it, he/she will likely mull it over at home, which can create long-term change (Greene & Lee, 2011).

### **Solution Focused Therapy (SFT)**

SFT focuses on the presenting complaint only and not on what caused the problem in the first place (Nichols, 2009). It focuses on changing one's actions, rather than the person as a whole. Clinicians believe that, while the causes of problems may be complex, their solutions do not need to be. SFT emphasizes cognition as well as behavior and language by helping family members to find forgotten solutions (Nichols, 2009). The approach is predicated upon the notion that, prior to the counseling, clients are stuck in repetitive patterns that blind them to potential solutions. Clinicians using SFT believe that a true problem exists only in language and thought, as it was constructed. Treatments focus on the perceptions, definitions and expectancies of the problem. It is believed that if the clinician-client relationship is strong, upbeat dialogue and optimism will occur.



SFT clinicians believe that problem behaviors are maintained as people define situations and in the misdirected actions that follow. People get stuck in their problems because, as they try to solve them by looking at the big picture, they often overlook solutions that are much simpler. The once-effective person who was able to change problem behaviors is hindered because of his/her negative mindset. SFT clinicians do not believe in labeling people with problems, as it means that they are static rather than dynamic (Nichols, 2009). Having a self-motivated and dynamic mentality is what will allow the client to make a lasting change. The SFT clinician believes clients have all of the strengths, resources and competencies they need to solve problems and achieve goals. Because each family is different with what behaviors are acceptable and what ones are not, the clinician does not always know what is best for each client. The client is the expert on his/her life, and therefore, just as he/she knows what the problem is, he/she knows what the solution is.

SFT clinicians work to help each family member to view things differently and find forgotten solutions, as they are the experts to their own problems. The clinicians believe reality is not objective; it is constructed with the use of language. The client explains his/her future goals, and the clinician only works to make those goals happen. They help the client to no longer be preoccupied with his/her failures by viewing the exceptions - when the problems were not occurring. The clinicians focus on the present and the future, rather than on the past. They try to keep therapy brief, as they do not want family members to dwell on the negative in their lives (Nichols, 2009). They begin with describing the problem, setting goals and then exploring solutions. It is important to use the SMART rule when determining goals. This stands for Small, Measurable,

Achievable, Realistic and Time-limited (Wolf & Bistline, 1998). After the goals are set, some examples of questions the clinician may ask are, “When the problem is no longer a problem, what will you be doing differently and what will you be doing instead?” and “What difference will the solution make for you?” SFT clinicians believe that if a change is made in one part of the system, it will affect change in another part of the system. The co-constructed relationship is important and is strengthened through validating the client’s feelings before any techniques are used.

The concept of the miracle question is very important to SFT. It invites clients to imagine possibilities by activating a problem-solving mindset and by helping them to see past their problems. The miracle question is “While you are sleeping tonight, a miracle happens. This miracle is simply that the problem you have come to address is completely solved. Since you were sleeping when this happened, you do not know that it occurred. Explain to me what things happen to let you know that the problem is solved. Explain to me what will be different in your life” (Nichols, 2009). This question is transformative and allows the client to reflect on his/her problem in new ways. It allows the client to have to accommodate to the novelty that he/she is feeling, and because of this accommodation, he/she can begin to experience second-order change (Greene & Lee, 2011). It allows the client to identify and reinforce his/her strengths, potential and resources that he/she already has. The elaborating and specifying that the client does when answering this question allow him/her to rediscover his/her strengths and abilities that he/she previously forgot. It works to broaden the client’s current frame of reality, since he/she is so focused only on what the impairment does. The client is able to find a newfound sense of personal agency, which is having the mindset that he/she is in charge

of his/her life (Greene & Lee, 2011).

Clinicians using SFT engage in solution/change talk rather than problem talk. Exception questions, coping questions and scaling questions are concepts that are very important to this type of therapy (Nichols, 2009). Exception questions help the individual to see that he/she already has access to potential solutions. This concept is similar to the unique outcome used in narrative therapy. Examples of exception question are, “Are there times when you do not have this problem?” “What is different about those times?” and “What will make it possible for more of that to happen?” Coping questions help clients to see that simply by living their lives, they are more resourceful than they thought. For example, even though the client has a hearing loss, he/she manages to get out of bed, feed their children and do things that require major effort. Examples of coping questions are, “How have you managed to carry on?” and “How have you managed to prevent things from becoming worse?” Scaling questions are useful in helping clients to assess their situations, track their progress and evaluate how others may evaluate them. They help to allow concrete behavioral changes and goals. The ultimate goal of scaling questions is to determine, on a scale of one to ten, where one is when therapy began and ten is when you are ready to terminate therapy, where are you on the scale today?” (Wolf & Bistline, 1998). Another example of a scaling question is, “On a scale of one to ten, where ten stands for you do not allow the impairment to rule your life and one stands for the opposite, the impairment gets in the way of every decision and action you make each day, what number would you give your present situation?”

Lastly, the concept of compliments is important, as clinicians act as cheerleaders

to be a positive light in the minds of the clients (Nichols, 2009). SFT clinicians try to convey a message at the end of each therapy session (Wolf & Bistline, 1998). These messages have three parts, which are compliments, bridging and a task or assignment to complete until the next therapy session. The bridge is simply a rationale for the clinician's message. Compliments are conveyed with questions and point toward what to do more, not what to eliminate more. These are important, as they bring forth respect for both the client and clinician's skills and show the common thread of the whole process of the client's accomplishments at once (Wolf & Bistline, 1998). It is all about how the question is phrased that allows the client to realize that he/she has already accomplished something (Nichols, 2009). Examples of compliments in the SFT setting are, "Wow, how did you manage that?" and "What kinds of activities have you done to be so successful?"

To give an example of the therapeutic techniques described above in the context of an audiologist and hearing aid client with a hearing loss diagnosis, a hypothetical dialogue between an audiologist and a hearing impaired client will be given. Hearing loss often creates multiple issues for the client and his/her family members. These issues will not be addressed without a strong rapport and knowledge of supportive counseling and various therapeutic techniques.

## **CHAPTER 4**

### **The Hypothetical Client**

The hypothetical client is in his fifties. He has a mild sloping to severe sensorineural hearing loss in both ears. His wife is frustrated with repeating herself and not connecting with him in a more intimate way, since he cannot hear most of her day-to-day speech. The wife is focused on blaming the client for why their relationship is not enjoyable. The client seems to keep to himself and does not want to try to wear hearing aids even though this is something that his wife believes is important and wants him to

do.

### **The Client's Presenting Problem**

The client's presenting problem is that he has a hearing loss that is causing him marital discord with his wife on a daily basis. He is unable to understand what she says unless she is looking right at him, and she is unwilling to work to help him to understand her. He feels that his wife is putting too much pressure on him because she does not understand that it is difficult for him to hear and completely understand her. They are unable to be intimate with one another because they often do not understand one another, and they would both rather watch television than try to talk to each other. The problem is worse when they are out in a noisy environment with friends, and this makes the client feel even more pressure because his wife takes the client's silence as being uninterested in her friends' lives. This creates a sense of the client being alone and makes him feel secluded from the world. The problem does not often occur while sitting at the dinner table, as they are facing one another.

### **The Client's Outcome Goal**

The outcome goal was determined through a co-collaborative rapport. The main goal for this client is that he has the courage to ask his wife and her friends to repeat themselves when he has trouble understanding what they are saying each and every time he has a difficulty. This goal will begin with the client asking the conversational partner to repeat himself/herself just once during the hour spent at a specific restaurant. The next time he goes out with his wife's friends, he will use these communication strategies twice during the hour that is spent together. Then he can try spending more and more time with the friends and allowing himself to feel free to be a part of the conversation for a longer

period of time. Each time that the client goes out with different people, he should become more and more comfortable with being a part of the conversation and not feeling ashamed to ask questions. The ultimate goal for this client is that he no longer needs to feel ashamed for being an important member of the conversations that occur in all of his daily environments. By working on these specific goals during short periods of time and with familiar people at first, he will be able to work on them in more difficult environments with unfamiliar people eventually. The hearing aids will surely help this process not to occur as often, as he will now have access to a greater portion of the conversation that he was missing.

Another important outcome goal for this client is that he and his wife spend each evening having dinner at the dinner table so that they can have meaningful conversations. It can begin with two nights a week or however many is comfortable for the client and his wife. The ultimate goal for this client is that he and his wife can have meaningful conversations every evening, and sitting at the dinner table will help this to occur sooner. The client needs to explain to his wife how important their relationship is to him, and he needs to help her see that communication is a two-way street. If it is important to her, she will need to help the client when he is having trouble, not just give up on him.

The following dialogues are examples of multiple sessions with the client. They represent progress the client has made over time.

### **Co-Construct a Collaborative Therapeutic Relationship - Motivational Interviewing Explanation**

“**What do you want for yourself today**” is an example of taking a one-down non-expert position.

**“I am wondering what sparked your interest in coming into the clinic. Something must have made you excited to make some changes in your life. What would you like to change in your life, specifically”** is an example of taking a position of curiosity.

**“What are you wanting for yourself today, and what would you like to change in your life”** helps him to understand that it is not the audiologist who will be making these changes but him.

**“I have to say that I think it is so telling that you came all of this way to try to get some help. It cannot be easy with the current stressors in your life, and it shows a lot that you decided to come into the clinic to move forward”** is an example of identifying the client on his successes and strengths. The audiologist helped to ensure the client knows that he is strong enough to make these positive changes in hopes that this will show him that he has the confidence to make a change and that his feelings are validated.

**“Of course. I am hearing that you are worried that all of the work will be put on you and that you may not succeed if this is the case. I am also hearing that you believe you have the strengths to make this change happen in your life”** is an example of being empathetic.

The audiologist is reflecting back his feelings so that he feels validated, yet understands he is strong enough to make this change. This is in hopes that just realizing that the client can do this will motivate him.

**“I will help you to see your potential once we assess your hearing loss and get the hearing aids fit appropriately. I think you will be surprised at how easily you can adapt and how well you will perform with the hearing aids. I will be here every step**



**of the way to work with you to get to where you would like to be with your hearing abilities**” is an example of being nonjudgmental and accepting.

“...**you to see your potential, how easily you can adapt and how well you will perform...**” was said to the client, as it shows him that he is the one who can make these positive changes. This is trying to help the client to understand that he is not alone in this endeavor and that there are many positives to making this change. It is also showing him that he has a readiness to change.

### **Dialogue**

Audiologist: What do you want for yourself today?

Client: My wife says I have a hearing loss and wants me to get hearing aids.

Audiologist: Do you think you have trouble hearing?

Client: I know I have a hearing loss, but I don't think it's that bad.

Audiologist: Do you think that something should be done about the current situation?

Client: Yes, I'd like to help my wife, and I would like to hear better, but I don't think a hearing aid is going to fix everything.

Audiologist: I am wondering what sparked your interest in coming into the clinic.

Something must have made you excited to make some changes in your life. What would you like to change in your life, specifically?

Client: Life at home is not that enjoyable, and I know my wife is only trying to make things better. I would like to be able to enjoy the time with my wife and have a mutual understanding that I am trying my best to understand her and would also like to have a more intimate relationship. I just need help. It just gets stressful dealing with the hearing loss and not understanding people most of the time. My wife doesn't understand that it is

as difficult for me to try to understand her as it is for her to try to get her point across.

Audiologist: I have to say that I think it is so telling that you came all of this way to try to get some help. It cannot be easy with the current stressors in your life, and it shows a lot that you decided to come into the clinic to move forward.

Client: Thank you. I do want something to be done about this hearing loss, but I do not want to be expected to hear everything right away.

Audiologist: Of course. I am hearing that you are worried that all of the work will be put on you and that you may not succeed if this is the case. I am also hearing that you believe you have the strengths to make this change happen in your life. It takes awhile for your brain to acclimate to the new sounds that it is receiving, as it has not heard them for quite some time. Communication is also a two-way street. Your wife will need to make sure she has your full attention and she is facing you before beginning to speak. You can come far if you both work together in order to communicate effectively.

Client: I would like to learn a lot more about these strategies you are talking about so that we can work together and so the blame is not all on my shoulders.

Audiologist: I will help you to see your potential once we assess your hearing loss and get the hearing aids fit appropriately. I think you will be surprised at how easily you can adapt and how well you will perform with the hearing aids. I will be here every step of the way to work with you to get to where you would like to be with your hearing abilities.

### **Establishing the Client's Presenting Problem - Motivational Interviewing**

Audiologist: Now that we have assessed your hearing loss, explain to me what your specific problem is.

Client: I am not able to enjoy time with my wife. She always complains that I do not

care about what she has to say and that I don't think our relationship is important.

Audiologist: What specific behaviors would you like to change?

Client: I would like to be able to have a conversation with my wife without having to ask her to repeat herself or having her complain about how I never listen to her. This should help us to become more intimate because we could get past the arguments and simply have real conversations.

Audiologist: Where does this problem most likely occur?

Client: This happens most days, but it is worse in noisy situations and when we are out with our family or friends. This makes my wife even angrier because she thinks I am ignoring her friends.

Audiologist: What does each person say or do when you do not hear them?

Client: They just look at me like I am dumb and move on to the next person. I often get ignored and am not part of the conversation.

Audiologist: Then what happens?

Client: I just stay quiet. I want my wife to have a good time with her friends, and I don't want to be a bother to anyone.

Audiologist: What do you think would happen if you asked them to repeat themselves and were actually a part of most of the conversation?

Client: I would never do that because I would be embarrassed. If I was able to do that, it would be freeing, and I would be able to connect on another level with my wife.

Audiologist: What do you think your wife would say about the problem?

Client: She would say that it is something that needs to be fixed or she does not think she will ever be happy again.

Audiologist: Explain what happens when this problem occurs at home with your wife.

Client: My wife will come home from work and find me watching television most of the time. She will say, "Hi" and ask how my day was. I am okay with that but when she asks specific questions or talks about her day, I need her to look at me and be more personal. I can't hear her from across the room.

Audiologist: Then what happens?

Client: I say, "What did you say?" Then she repeats herself and I answer and then she goes upstairs. We often don't talk again until the dinner table.

Audiologist: At the dinner table, what happens?

Client: Actually, the dinner table is a time when I do easily understand her since it is quiet, and she is looking at me. We haven't been eating at the table, though, for a while because it's just easier to watch television while we eat.

Audiologist: Since the dinner table seems to be the place where the problem is least likely to occur, how come you don't spend most nights eating there?

Client: I think we are fed up with each other by the time dinner starts, so it is more enjoyable to watch television. I think she just doesn't want to work any harder at talking to me.

Audiologist: On a scale of 1 to 10, 10 being a problem-free, where do you lie at this time?

Client: I would say that I am at a 2.

Audiologist: How has this problem or the hearing loss evolved over time?

Client: It has just gotten worse. I have tried to ask people to repeat themselves, but it just makes me feel bad, and other people just don't care enough to keep talking to me.

To try to make my wife happy, I have stayed quiet instead of bother her and her friends, but I think this makes it worse. By not actively trying to have conversations with my wife, it has led us down a path of barely conversing and spending most of our evenings doing separate things.

### **Externalizing the Client's Presenting Problem - Narrative Therapy**

Audiologist: I'd like to talk about the problem and understand how it has interacted with your life.

Client: You mean my hearing loss?

Audiologist: I mean the hearing loss. I sometimes like to look at the problem as something that is outside of you and then ask about the influence it is having on you. I find this helps bring a new perspective to the problem, which can help us find ways to deal with it. Is it okay if we experiment with talking like this for a bit?

Client: Sure, that sounds good.

Audiologist: How long has hearing loss been a part of your life?

Client: It happened gradually, but it was not a problem with my wife and I until about five years ago.

Audiologist: How has hearing loss changed over time?

Client: It used to be something I could overlook because it was not that bad, and social situations were still enjoyable, but now it is something that influences how I interact with the world. It is something that is constantly there.

Audiologist: How do you feel when hearing loss is trying to push you around?

Client: That's an interesting way of looking at it. I don't like when it takes control of my life and makes me sit out of conversations. I get angry, which makes me even less likely

to engage with people.

Audiologist: What kind of things does hearing loss tell you about yourself?

Client: It tells me that I am not worthy because I cause too many headaches for people around me. It tells me that I am better off being alone. It makes me feel small and unimportant.

Audiologist: What has the hearing loss stolen from you? What enjoyment has it taken

from you? Client: It has taken away my free will because I do not feel free to do what I like anymore. I am more likely to sit at home or go to the driving range alone than to enjoy time with friends. There is too much work that I have to do to interact with others, and there is so much room for frustration to happen. It was okay at first until it started to affect my relationship with my wife.

Audiologist: What effect does hearing loss have on your wife?

Client: I would say it makes her angry with me. She does not like it because it has changed the way we interact and the way I behave myself around her and her friends. She would like to go back to the times before the hearing loss had a hold on me.

Audiologist: Are there times when you were able to stand up to hearing loss and have it be like before the hearing loss had a hold on you?

Client: Actually, sometimes I am able to forget about it. Like when my wife and I are laughing and having a good time at the dinner table, for example. It doesn't even cross my mind. I am able to make a joke and talk to my wife about our future traveling plans, which is something we don't often do.

### **Use of Unique Outcomes/Exception Questions - Narrative and SFT**

Audiologist: Oftentimes, between the time an individual calls to make an appointment

with this office and the time of the first appointment, he experiences some positive changes in his problem. Is this true for you?

Client: It was my wife who called to make the appointment in the very beginning.

However, since that time, I knew that I would have to make some changes. I knew that I would have to begin talking and reaching out to my conversation partners more. This happened just last week when we went to a restaurant with my kids. Usually, I take a backseat approach and allow my wife to ask all of the relevant questions, but I came up with a few and had a nice conversation with my daughter who is currently in college.

Audiologist: How were you able to do this?

Client: I just thought to myself that there are going to be hard times ahead, and I might as well try to help myself now. Nothing is going to change if I keep feeling sorry for myself. I also realized that I do not often get to see my daughter, and any time spent with her is a special one. Hopefully I can start to take this attitude to my wife.

Audiologist: When you first called to make the appointment, where were you on the 1 to 10 scale, and where are you today?

Client: I would say that before this all began, I was at a 1 and felt that there was nothing I could do. At our first appointment, I think I told you that I was at a 2. Honestly, today I feel that I am at a 4. This is because I have been able to see what the future holds if I continue to make these positive changes and simply work at having better relationships.

Audiologist: Wow! A 4 means you are almost at the halfway point! Since you said that you were at a 1 before you came in, you have come a long way.

Client: I guess I have. Good things are happening each day and with each new thing I learn from these appointments.

Audiologist: To what extent are these changes the kind that you would like to continue to have happen?

Client: These changes where I open up to my family and try to hold conversations are what I needed help with when my wife made the first appointment. I would like more of this same change to happen to where I can become so comfortable with myself that I do not feel ashamed at all to ask someone to repeat himself.

Audiologist: Moving on from the changes that you made before you came to see me a few weeks ago, when are there times in which you are feeling happy and not so ashamed of yourself?

Client: The times when I am with my wife and she is enjoying herself or the times when I am with the rest of my family and everyone is happy. They happen so infrequently, so when they do, I am happy and try to make them last by holding a conversation.

Audiologist: When are those times that you and your wife get along like that?

Client: Most of the time, it is when we are talking about an old friend or someone who my wife had had lunch with that day. It is fun when we both have a mutual interest for the topic at hand and are able to overcome our differences and work together to make the conversation run smoothly. When we do take the time to eat dinner together at the table and I get to look into my wife's eyes, I know that I want to make changes and enjoy the time that I have with her.

Audiologist: What are you doing differently during those times with your wife?

Client: I am fully engaged and make sure I ask when I need clarification in a way that is not bothersome or rude but just so that I can enjoy the conversation. I ask her questions, rather than keeping to myself.



Audiologist: How were you able to get that to happen?

Client: I was able to get that to happen because it's what I used to do before I had to deal with this hearing loss. I just kind of forget about the hearing loss for a second and act as if everything is normal because I am not worrying so much about it. I am able to be my fun-loving self who I was when I first met my wife. She makes it easier, too, as she is engaged and desiring me to have a full conversation, as well.

### **Use of Positive Reframing Dialogue - Narrative Therapy**

#### **Explanation**

This client's current frame is that he is a person with hearing loss who is unable to connect with the people in his life in a way that is positive. He only sees all of the bad aspects of his life with his wife, since most of their interactions are negative. When good things do happen, he often forgets them because they do not fit into his current frame or state of mind. He views his hearing loss as himself, rather than as a problem that he can work to change for the better.

#### **Dialogue**

Audiologist: I would like to talk about some of your strengths today.

Client: I don't have many strengths.

Audiologist: How so?

Client: As we have been talking the past few weeks, I have only mentioned all of my issues that cause my wife and I to interact negatively.

Audiologist: Provide an example of a recent interaction you both had.

Client: I was in the living room watching television while she had some friends over for cards. I did not get up to greet them because I did not want to not hear the conversation

fully. She had an argument with me later about how I seem so distant and couldn't care less about her friends.

Audiologist: I have seen a very different person than the one you describe as being distant and uncaring. I think you are a kind individual who only wants people to enjoy themselves. I see what your wife calls distance as a thoughtfulness for her friends' well-being.

Client: I've never thought of it that way, as it only causes negative problems. I guess if my wife could see it that way, it would be nice. She just gets angry and begins to point out all of my problems.

Audiologist: I think your wife might not see any other way to shake you of your silence than to yell and make a statement. She may think that if she didn't do that, you two would never talk. She cares for you so much that she would rather argue with you than be silent and not try to work things out as she sees fit.

Client: I guess that makes sense. It would be worse if she just stayed silent and did not want to talk about our problems. I will keep that in mind the next time we just cannot seem to see eye to eye and remember she only wants the best for me.

Audiologist: That is a great idea. It will help you to see the positive aspects of your relationship, as it is strong, and your wife wants to keep that bond with you, rather than let it fall apart.

### **Use of The Miracle Question - SFT**

#### **Explanation**

The miracle question helps the client to more concretely see what his goal would entail and what he can look forward to if he actually works toward wearing the hearing

aids. It is a fun and unique way for the client to see what is in store if he just works with what he has and stays strong. The miracle question helps the client to experience unguided imagery, which is when the client is the author to his new story (Greene & Lee, 2011). This exercise should have helped him to become excited in what is in store for the future. It will also help him to understand that he is strong enough to make these positive behavioral changes occur.

### **Dialogue**

Audiologist: Pretend that, while you are sleeping tonight, a miracle happens. The miracle is that the problem of hearing loss, which brought you here today, is solved. The problem is completely gone. Only you do not know that it is solved because you were asleep when it happened. What difference will you notice tomorrow morning that will tell you that a miracle has happened? What is the first small thing you will notice?

Client: I will notice that I can hear my wife getting ready in the morning. She doesn't like that I sleep in and don't get up to say, "Good morning," but I often can't hear that she is awake.

Audiologist: What else would tell you that things are better?

Client: My wife would be having a conversation with me because she knows I can hear her and isn't even thinking about all of the consequences of beginning a conversation with me.

Audiologist: What else will your wife be doing differently?

Client: My wife would be engaging with me, not just having a surface conversation. She would be happy that I am awake and spending time with her.

Audiologist: What will you and your wife be doing instead of arguing or watching

television in the evening when you are both together?

Client: We would be laughing at the dinner table together. She would see that I am working to understand her and will be able to forgive all of the times before when I simply acted as if I didn't hear her in order to not have to work so hard at understanding her. We may even be talking about a vacation that we have put off in the past few months because there are no more issues with understanding what her goals for the trip are.

Audiologist: What would be different when you are out with your wife's friends in a noisy environment?

Client: I think I would have a lot more enjoyment out of spending time with friends because I would be hearing everything that is happening. I could even be the life of the party like I used to! I would hopefully help them see that I am not a quiet and boring person. We would be talking about how the football game went and talking about the camping trip we have been planning.

Audiologist: You are saying that the miracle is when you have no hearing loss, and you and your conversation partners could talk freely. What do you think might happen if you are fit with hearing aids?

Client: I think this situation would be very possible. I understand that it will take time for things to sound like they used to, and I will not be able to understand everything that is said to me right off the bat, but it will give me the motivation to try to engage with others and have a better relationship with everyone.

## **CHAPTER 5**

### **CONCLUSION**

All audiologists can show supportive counseling during a session with a client. This refers to understanding the emotional and psychological responses to the hearing loss. Individuals who are solely learning about their particular hearing loss or using hearing aids for the first time are likely to go through various emotions, which may include embarrassment, frustration, anxiety, depression, or fatigue. It is important that audiologists understand the necessity of counseling for individuals, as they are most

likely going through new emotions and are not sure how best to cope with their new situation. The audiologist is often the only person in the older adult's life who fully understands the situation that he/she is experiencing, and he/she can benefit from reassurance and knowing that his/her life will, in fact, benefit from the use of hearing aids. It is also more likely that an individual will consistently use his/her hearing aids and enjoy them if he/she is confident in his/her abilities and are at peace with his/her new emotions. Audiologists are the role models and supporters for those who feel relief that they now have all of the answers about their specific situation. They have the influence to help a client feel more autonomous and self-confident. Their family members and friends may not understand the emotions that they are experiencing and are not always able to provide this help.

With a prior understanding of supportive counseling, it does not take much more effort to understand various therapeutic techniques in which audiologists are able to apply to clients. When an individual learns that he/she has a hearing loss, he/she is likely to have relational issues as the communication has been negatively influenced in a physical way. This may cause a family member to believe that the individual is not listening or does not care about what he/she has to say. There are ways to physically change the way an individual hears, but it is most often relevant to have a "toolbox" of techniques in the audiologist's mind for that particular individual who is having greater difficulty communicating with his/her family members. These therapeutic techniques may not only positively benefit the client but his/her family members, as well.

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