Motivational Interviewing

for Hearing Care Providers

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Preface

My mother was 3 years old when they discovered she was deaf. Her parents were told she would not survive in the public school system, and they were advised to manage their expectations for her future. However, even at 3 years old, my mother was determined to defy expectations. She pushed to attend regular public school and hid her hearing aids from her peers and teachers. She worked tirelessly to compensate for her hearing loss and excelled socially, athletically, and academically. At the University of Waterloo, she was awarded the Governor General's gold medal for achieving the highest academic standing in her graduating class. She earned a master's degree in kinesiology and became a physical education teacher (and coach) for 30 years.

When she married my father, he realized this meant a lifetime of hearing aid purchases. Determined that she should never worry about being without hearing aids, he studied electronic design at Sheridan College. At the time, his goal was to learn how to repair her hearing aids when they broke. Not only did he succeed, but he eventually went on to engineer new hearing aid offerings from Dahlberg Sciences. Eventually, he oversaw production for Dahlberg Canada and taught small circuit design to Hearing Instrument Specialists at George Brown College. When I was a child, he lovingly crafted my first pair of hearing aids as well. When my mom's three brothers also got hearing aids, he found himself popular at family gatherings, cleaning hearing aids and conducting listening checks.

Today, my parents are retired and enjoy life together. My mother still refuses to let hearing loss hold her back and is often the life of the party. My father still retubes her earmolds and patiently repeats himself. I grew up in what I consider to be a "hearing loss culture" because so many family members wore hearing aids, used amplified phones and closed captions, and practiced accessible communication strategies. Due to this and my own hearing loss experiences,

I understand how hard it is to break down the barriers faced by those with hearing loss. I also understand the importance of using hearing aids for maintaining social connections and engaging in meaningful interactions. So, after 5 years of studying psychology at Wilfrid Laurier University, I decided to pivot and follow in my father's footsteps instead. I enrolled in the 2-year Hearing Instrument Specialist (HIS) diploma program at MacEwan University in Alberta, Canada. Then I joined the audiology team at Demant Canada, where I felt I had the best platform to support both hearing care professionals (HCPs) and patients.

It was during my time in technology support that I noticed a recurring challenge. HCPs who called for support often struggled—not because they lacked technical skill or knowledge, but because their interactions with patients had become strained. Many HCPs had taken on the responsibility of problem-solver, leaving their patients pointing fingers when setbacks occurred. These well-meaning HCPs genuinely wanted to help, but they seemed hesitant to ask the patient for details or to participate in the troubleshooting process, perhaps fearing that asking questions would undermine their expertise. This dynamic can lead to conflict, with clinicians feeling defensive and patients feeling frustrated or let down.

Witnessing these strained interactions set me on a new path, prompting me to wonder how to improve communication between HCPs and patients, especially when challenges arise. Motivational interviewing (MI) became the cornerstone of this journey. After taking courses at the University of Western Ontario, I felt that MI held promise for hearing care counseling. MI was not just a tool for better relations—it was a pathway to better outcomes for both clinicians and their patients alike.

Eager to share this approach with others, I began teaching for the HIS program at Humber Polytechnic in Toronto. I re-designed the patient counseling course to place the MI spirit at its core. The hard work paid off, and the results of incorporating MI into HIS counseling were immediate and remarkable. It provided a glimpse into how MI could transform how HCPs approach their work. However, once these students graduated and began their placements, they told me they were reinstructed by their supervisors on how to interact with

patients. Most were obligated to conform to the companies' philosophies and procedures, which differed significantly from what I taught in the classroom. I watched from afar as the industry inadvertently deterred graduates from using the MI approach.

It appears that for MI education to penetrate future careers, it needs to be embraced by the HCPs training them in the field as well. I recently finished a Master of Education to help create more meaningful and far-reaching MI learning experiences. I developed numerous resources centered on using MI in hearing care, including a 6-week online course with Pacific Audiology Group. With each project, my understanding and vision improved. I also received growing support from individuals who recognized the value of MI for hearing care. With the closure of the Ida Institute in 2024, it became increasingly clear that a comprehensive resource was needed for HCPs seeking to integrate the MI approach into their practice. And so, this book was born—a culmination of years of curiosity, exploration, reflection, and personal growth. It reflects my deep commitment to improving outcomes for both HCPs and hard-of-hearing individuals alike.

Before we begin, I would like to address some housekeeping. Throughout this book, I address the reader directly, reaching out to you as a fellow hearing care professional who aims to help individuals manage their hearing loss. When I say "we," I think I refer to many of us in the hearing care field, including myself. The voice I bring to this conversation about hearing care practices is both informed and limited by my experiences. I consider myself a learner and scholar on a long journey that I have not yet completed. I use a casual tone in a conscious effort to speak to a broad audience of readers, creating a resource that is as accessible to the new student as it is to the seasoned practitioner, in the hope that this can support a cohesive industry movement.

The patients described throughout this book are adults with acquired hearing loss, often due to presbycusis or noise-induced hearing loss. As a Hearing Instrument Specialist (HIS) by trade, this population represents a significant portion of my training and experience. It is also the most significant demographic that HCPs work with, as an estimated 60% of the adult population experiences hearing problems. Additionally, with half of these adults unaware

of their hearing loss, the hearing care industry's capacity to address early hearing loss will play a critical role in supporting the health of our aging population. This book is in no way intended to motivate individuals who identify as Deaf to pursue amplification.

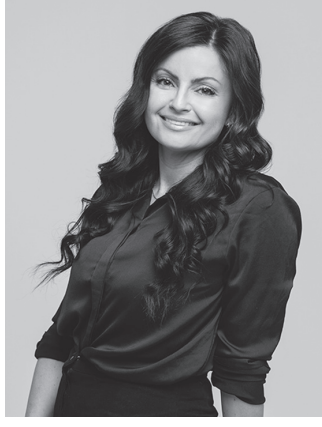
I use the terms *HCP* and *clinician* interchangeably throughout the book to refer to hearing care professionals in general. I found that using the acronym HCP too frequently impacted the book's readability, so I have opted for *clinician* at times. Furthermore, I may appear to equate "treating hearing loss" with "buying hearing aids." I appreciate the breadth of aural rehabilitation and the array of assistive devices that can help patients manage hearing concerns. I believe that deciding to purchase, wear, and care for hearing aids is one of the most significant and impactful choices a patient can make. Additionally, I live in Canada, where over the counter (OTC) amplification options are not yet available, and Ontario residents receive provincial assistance with hearing aid costs, making hearing aids often a substantial part of treatment. As a Hearing Instrument Specialist, hearing aid wearer, and professional working with hearing aids, I have applied the MI principles, as I understand them, to the areas I am most familiar with. Also, by using the decision to pursue amplification as the main example throughout this book, I was able to provide the reader with a more coherent narrative. It would not make sense to write about topics in which I lack expertise and training, such as pediatrics, cochlear implants, or tinnitus treatment. However, I encourage the reader to explore the ideas within this book in these contexts, if appropriate and within their scope of practice. Lastly, I have chosen to use the word "patient" throughout this book; however, in some contexts, "client" or "customer" may be more appropriate as well.

The final comment I wish to make concerns the ethics of using MI in hearing care, particularly since the HCP benefits financially when a patient purchases amplification. MI is a conversational style that empowers the HCP to guide individuals through the decision to address their hearing loss. MI can be an effective tool, and like all tools, it has the potential for misuse. MI may not be suitable for patients with developmental and/or cognitive considerations that limit their ability to collaborate and make informed decisions. I envision MI as being used in hearing care when working with adults who

have self-initiated an appointment at a hearing clinic or are seeking some assistance with their difficulties. These patients have already taken a step toward self-improvement, and MI allows them to continue their forward momentum. As a positive but *secondary* outcome, I believe that HCPs who utilize the principles of MI will also find financial benefits in their practice. Nevertheless, with great power comes great responsibility, and the HCP must ensure that the goals being addressed always belong to the patient and no one else.

Without further ado, let us begin.

About the Author



Bobbi-Jo Marlatt is a passionate Hearing Instrument Specialist who has worn hearing aids since childhood. After earning her BA in Psychology, she became an HIS and later pursued a Master of Applied Health Sciences and a Master of Education. Currently, she is completing her PhD at the University of Western Ontario, where she is researching motivational interviewing in hearing care.

For over a decade, Bobbi-Jo has worked with Demant, supporting and training hearing care professionals across Canada. She was instrumental in designing the Hearing Instrument Specialist Program at Humber Polytechnic, where she also serves as a professor specializing in professional practice, ethics, and patient counseling.

Her dedication to advancing hearing care extends to her role on the Board of Directors for AHIP in Ontario. She is also a member of the Canadian College of Health Leaders and holds the Canadian Health Executive (CHE) credential.

Bobbi-Jo's interest in motivational interviewing led to a collaboration with the Pacific Audiology Group, where she helped develop a six-part MI training program for hearing professionals, along with accompanying blogs, videos, and articles. Her work is driven by a passion to increase hearing aid adoption through enhanced patient-provider communication.

When she's not working, Bobbi-Jo enjoys gardening, being at her family cottage, having bonfires, cooking, running, and spending time with her family—and their beloved flock of birds—in the backyard.

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What Is Motivational Interviewing?

Making the transition from fixer to guide relieves you of the stress and weight of having to solve behaviour change issues for patients and instead help them to do this for themselves.

—Rollnick et al. (2023)

Introduction to Motivational Interviewing

Motivational interviewing was born in 1982 when William Miller, a psychologist, was asked by an apprentice why he had responded the way he did in a role-play counseling activity (Miller, 2023). This question prompted Miller to realize that he had been unknowingly following a set of rules about how to respond to patients when counseling them, particularly those suffering from alcoholism (Miller, 2023). Miller attempted to document these rules in a discussion paper, labeling his strategy "motivational interviewing." Much to his surprise, someone published his paper, introducing motivational interviewing (MI) to the world. In this way, MI was not born from a preexisting theory but rather from simple observation of remarkably productive conversations that were taking place (Miller, 2023). It was a result of the tacit learning that had taken place after years of addiction counseling experience.

The words chosen to describe this counseling style reveal a great deal about what MI is. **Motive** means moving or tending to move toward action (Merriam-Webster, 2024c), and **interviewing** means approaching someone with a request for opinions and/or information (Merriam-Webster, 2024b). Thus, **motivational interviewing** involves asking someone why they want to do something and gathering details on the direction they wish to move. The primary goal of hearing care is typically to improve hearing. MI is a conversation style that enables hearing care professionals (HCPs) to conduct purposeful conversations that aid the patient in making a desired change (Rollnick et al., 2023). This change is centered on treating and managing the chronic condition of hearing loss and is driven by the consequences that untreated hearing loss has for the patient. Conversations conducted in the MI style increase the likelihood that the patient will act and the likelihood of maintaining that change over time (Rollnick et al., 2023).

An HCP trained in MI learns to pay particular attention to the language being used by the patient. The HCP must listen carefully to what the patient is saying and then select their own responses just as carefully to guide the session. MI-trained hearing care professionals become intimately aware of how the questions they ask can impact

the outcome of the appointment. They ask questions that encourage the patient to discuss their motivation for change, for example, "Why did you want to get a hearing test? Why now?"

Ambivalence refers to simultaneous and contradictory attitudes or feelings toward an object, person, or action (Merriam-Webster, 2024a). Feeling two ways about something is normal in many aspects of our lives. People often contemplate things like, "Should I get a new couch?" "Should I go back to school?" "Am I exercising enough?" or "Should I switch jobs?" At various points in our lives, it is normal to weigh the pros and cons of making health behavior changes, career changes, or big purchases. Continually fluctuating between the options and experiencing uncertainty in which path to take and when is a part of being human. MI counseling helps individuals explore and resolve this ambivalence to change. In MI, clinicians must ask the right questions to encourage patients to verbalize their reasons for wanting to change. This not only allows the HCP to learn about the patient's pros and cons but also builds the patient's motivation. When the patient attempts to convince us why this change is important to them, they often end up convincing themselves. Therefore, if we guide the conversation appropriately, they may finish a simple conversation feeling positive about making a change.

There are two other terms this book will use when discussing ambivalence: **Change talk** refers to reasons that the patient feels support making a change (e.g., not hearing the TV, phone, grandkids, work, siblings), and **sustain talk** refers to reasons that the patient feels that support staying the same (e.g., stigma, cost, appearance, technology skills, other health conditions). When MI is done correctly, patients will share both change talk and sustain talk with their provider, allowing them to weigh the two and determine which column is heavier. Ambivalence is normal. Patients usually cannot move forward until their indecision is resolved. Conversations with patients should be a supportive dialogue where the patient feels safe expressing both sides and empowered to make a positive choice. This guiding style should be very rewarding for everyone involved! It can be a relief for the patient to finally decide on a course of action, knowing it was the right choice for them. Moreover, the clinician gets the satisfaction of knowing they helped them find a positive path forward.

In the foundational book, *Motivational Interviewing in Health Care: Helping People Change*, Rollnick et al. (2023) begin with a sentiment shared by health care workers that resonates among HCPs as well:

> You invite a patient to change this or that behaviour, and the response is one of ambivalence or even refusal. This dilemma is universal, as are efforts to persuade people out of the behaviour. The problem is that simply telling others what to do is usually not enough to motivate them to do it. (p. 1)

Health care statistics increasingly show that giving expert advice and insisting patients adhere to it is often unsuccessful. This observation has led to an uptick in interest in MI by many health care professionals. Today, MI is being utilized in a growing number of health care settings, far beyond its original application in alcohol counseling.

In hearing care, the HCP is often viewed as the "expert" whose role is to inform the patient about the importance of treating their hearing loss and the best course of action. As Rollnick et al. (2023) note above, attempts to motivate the patient **extrinsically** are often unsuccessful. Exerting considerable effort to motivate patients may be why some well-meaning HCPs feel burned out in the clinic, experiencing compassion fatigue when counseling efforts are ineffective (Rollnick et al., 2023). After a frustrating appointment, a common sentiment might be, "If they didn't want my help, then why did they come in?" Often the HCP cannot *give* the patient intrinsic motivation by listing reasons the patient *should* feel motivated. This directive approach ignores the fact that the patient already has reasons for being motivated. We know this to be true because they've made a decision to come for the appointment. By attempting to create something new and ignoring what already exists, the directive approach is a much more strenuous and precarious path.

Old habits die hard. We know so much about hair cell damage, new hearing aid technology, cochlear implants, bone-anchored hearing aids (BAHA), and wireless connectivity. The mistake

practitioners make in most situations is that they see their task as just supplying information—cold hard facts and descriptions. They want to be Mr./Ms. Informative. However, we often are not comfortable managing patients' affect or emotional statements. As a result, we are often not tuned in to a patient's feelings during a hearing care visit.

—Citron (2020, p. 32)

Experienced HCPs reading this have likely witnessed that external pressure does not foster consistently positive outcomes. How many times has a patient who is struggling daily received your recommendation to obtain amplification and declined to proceed? Or how many times has a patient's spouse declared, "I have been telling them to come for a hearing test for years!" but the patient continues to ignore them? Telling people "You should," "You must," or "You need to" can make people determined to assert their freedom of choice. This phenomenon is known as **psychological reactance** (Brehm & Brehm, 1981).

Psychological reactance occurs when an individual feels that someone is infringing upon their right to make a choice or that they are being pressured into a certain course of action (Brehm & Brehm, 1981). The result of applying external pressure is that the individual experiences a strengthening of their contrary feelings, behaviors, and attitudes (Brehm & Brehm, 1981). This reaction increases the patient's cognitive resistance toward external persuasion (Rollnick & Miller, 2023). Citron (2020) notes that if an HCP gives in to their righting reflex (or fixing impulse) and starts pulling the patient toward what they consider the good side of the argument, they are forcing the patient to take up the opposing side. By trying to persuade the patient, they are actually making the patient less likely to comply.

Psychological reactance in hearing care is evident when individuals who were motivated enough to make an appointment disregard the HCP's expert advice and leave feeling they do not need/want hearing aids as a result.

From this perspective, it is in part due to the HCP's attempts to help them that many individuals are opting to live with an untreated chronic condition. This suggests that if the HCP wants to reduce the number of years lived with hearing loss, it would be wise to avoid relying on external pressure. Rather than counting on expert advice from the HCP or banking on the persistence of family members, the HCP can use MI to shift the focus of the conversation onto the patient's motivations, allowing them to convince themselves. Thus, MI re-envisions the hearing care professional's role from one centered on education and advice to one that taps into and amplifies the intrinsic motivations already within the patient. The HCP is not creating motivation because MI does not push a patient in a direction they did not already intend to go. Instead, they build motivation by allowing the patient a chance to verbalize and reflect on it.

Furthermore, a clinician utilizing MI techniques does not need smoke-and-mirror distractions to handle and/or overcome objections. "You are worried about the cost? Look at this payment plan!" or "You are worried about the size? Look at how small this one is!" Instead, MI acknowledges and explores mixed feelings, never pushing them aside in favor of immediate action. Chapter 4 discusses the roadblocks to effective listening, and many of the "objection-handling" strategies are listed there, along with a detailed explanation of how these behaviors can be detrimental to patient engagement and motivation outcomes.

How MI Improves Listening

MI conversations center on curiosity, empathy, and respect (Rollnick et al., 2023). The HCP demonstrates curiosity by asking questions that encourage the patient to share their whole perspective. The HCP appreciates that each individual's experience of living with untreated hearing loss and their decisional balance around amplification is subjective and unique. The HCP takes care to avoid assumptions. Instead, they ask the patient to air out the landscape (both the good and bad) as they perceive it. Allowing space for objections shows respect for the patient as an individual who is experiencing conflicting thoughts,