

# What Your Patients May Not Tell You

Combating deep metaphors and the rationale for audiological-psychological collaboration

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Interactions between hearing care professionals and their patients are sometimes fraught with post-trauma reactions and other psychological landmines for which psychological collaboration would be beneficial.

As their psychologist, patients with hearing loss often tell me what they haven't told their audiologists or hearing care professionals. For example:

- A patient felt disempowered by his progressive hearing loss and attempted to empower himself by routinely missing audiologic appointments.
- A middle-aged man reported that, despite his audiologist explaining how hearing aids would enable him to live more happily, she reminded him of an undertaker: "Hearing aids would be the beginning of the end, a giant step toward my death."
- A 68-year-old woman told her audiologist she wanted hearing aids but told me she had no intention of getting them as it would only make her know-it-all adult son more smug.
- "I know it makes no sense, but getting hearing aids will make my hearing even worse than it is now." (In the psych literature, this is called "magical thinking.")
- "A hearing aid is like a Scarlet Letter that will make the world mock and pity me."
- "Going to Dr Smith makes me feel guilty, because I know that I should have taken care of my hearing better."
- "Although I may hear better, I'll feel more [flawed, old, stupid, defective, deficient, ugly, weak, shut out, etc]."

People with hearing loss may also tell a stranger, such as a marketing consultant, some of these personal sentiments that they may not share with their audiologists. The quotations from patients in my practice, noted above, echo a survey conducted by marketing consultants Zaltman and Zaltman<sup>1</sup> that elucidated what they termed

"deep metaphors" that people had associated with hearing loss and corrective devices. They found that "[Younger and older] consumers felt that their hearing devices conveyed deficiency, weakness, breakage, and ugliness —the opposite qualities that society at large values." They concluded that "Ultimately, the overwhelming stigma and the associated fears discouraged consumers from reentering the normal hearing world with hearing aids."

Zaltman and Zaltman's<sup>1</sup> conclusions are consistent with anecdotal reports by hearing care professionals and empirical survey data. In the most recent MarkeTrak VIII report on the 25-year trends in the hearing health market, Kochkin<sup>2</sup> found that "[although] the hearing loss population grew at the rate of 160% of US population growth, to 34.25 million persons... less than 1 in 10 people with mild hearing loss use amplification, and 4 in 10 people with moderate-to-severe hearing loss use amplification for their hearing loss."<sup>2</sup>

This article provides an analysis of common patient psychological dynamics and patient-audiologist interactions that help explain poor patient adherence to amplification recommendations. I will address two related fundamental questions:

- 1) Why might a particular patient with hearing loss fail to tell his/her hearing care professional of their feelings related to "overwhelming stigma" that discourage hearing aid use?
- 2) What psychological tools can the hearing care professional use to facilitate a fuller, more open affective (emotional) dialogue with patients and therefore facilitate adherence to recommendations?

## Traumatic Transference

I asked Sue whether she thinks her pulse rate changes at her audiologist's office. Instantly, she nodded her head and I asked why. "He's very nice and supportive," she began. "He tries to make me relaxed and to focus on the positive, but



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I feel defensive with him, like he's gonna keep finding things wrong with me."

"Have you shared your feelings with him?" I asked, already suspecting her answer.

"Of course not!" she immediately responded. "He probably already thinks I'm a basket case."

Sue wasn't a "basket case" and her sudden situational anxiety isn't unusual for patients who visit a health care provider. She described what physicians refer to as the "White Coat Syndrome": when patients have a high pulse rate or high blood pressure in the doctor's office but nowhere else. Physicians are keenly aware of the high prevalence of this phenomenon, as they can physically monitor patients' vital signs and don't need to depend on self-report. Not so for audiologists.

"Who else do you imagine thinks of you as a basket case?" I asked.

"You very well know that my mother does."

She was right. As Sue's psychologist, I did "very well know" about her difficult relationship with her mother; Sue viewed her as judgmental, critical, and condemnatory, and the childhood diagnosis of Sue's hearing loss added more tension to their already strained relationship.

Although this psychological information was extremely relevant for her audiologist to better understand the dynamics of their relationship and to facilitate her adherence to his amplification recommendations, elicitation of this information was beyond his scope of training. Furthermore, his asking versions of "Tell me about your mother" would at best be perceived by Sue as irrelevant and, more probably, be perceived as intrusive.

This is easy to understand. While I am not suggesting that standard hearing evaluation protocols include these psychological inquiries, I am noting that knowledge of psychological factors is frequently critical for successful treatment and that Sue's audiologist, for example, was handicapped because he was not privy to this information. He didn't know that, although on one level Sue experienced him as "nice, caring" professional, on another level she experienced him like her mother who will "keep finding things wrong with me"—and that she therefore continually kept up her guard with him, with an increased pulse, while doing her best to appear relaxed. She was caught in a *Catch-22*: she depended on his expertise, but was terrified of her vulnerability and dependence.

Although the details vary, in my three

decades of providing psychotherapy for people with hearing impairment, I have routinely heard versions of Sue's story. The process of diagnosing and treating one's hearing loss often catalyzes the re-experiencing of painful emotional reactions that had been associated with earlier losses or trauma.<sup>3-6</sup> To the extent that incurring a hearing loss is experienced by a patient as psychologically traumatic, an audiologic visit is likely to trigger a complex series of post-trauma psychological reactions as it did with Sue.

"That doesn't make sense," a hearing care specialist once told me. "How can my patients re-experience the trauma of losing their hearing while I'm giving them effective treatment? I show them compassion and help them hear better so that they can lead more fulfilling lives. I repeatedly tell my patients that I represent the *solution*, not the problem!"

I reminded him that, although Sue described her audiologist as "very nice," "supportive," and as "focusing on the positive," she nevertheless felt defensive and flawed with him. These dynamics were not caused by the compassionate and competent audiologist, but nonetheless profoundly influenced their interactions.

**Trauma and hearing loss can be intertwined.** How might this dynamic occur? Trauma and major loss—such as substantial hearing loss—are frequently intertwined; both are characterized by heightened anxiety, helplessness, and fear. Unlike normal experiences, traumatic loss is neurologically processed in the amygdala and limbic system and is prone to being reactivated or triggered even at a much later time, particularly by stimuli or events that remind one of the early trauma (eg, an audiologic consult). Neurological survival circuits are reengaged and a person shifts into emotional survival mode.<sup>7</sup> One may experience persistent re-experiencing of circumstances associated with the hearing loss, flashbacks, nightmares, engage in behaviors designed to avoid reminders of the trauma, and become hypervigilant, or on "red-alert," for further losses of hearing. As LeDoux<sup>8</sup> aptly put it, the amygdala leads a "hostile takeover of consciousness by emotion."

This kind of post-trauma reaction is termed *traumatic transference*, an unconscious dynamic that happens when someone has been traumatized and is later in a situation that reminds him/her of that trauma. One transfers the emotions that were associated with an earlier traumatic situation onto a present-day situation that

is perceived as similar. For example, a woman having been raped by a man is terrified when meeting a similar looking/acting man; a military veteran, having been subjected to wartime bombing, finds himself in combat position during a thunderstorm. Metaphorically, transference is when one uses an outdated roadmap.<sup>9</sup>

### Trauma Isn't a Four-letter Word

At the keynote address in 1999 for the Academy of Dispensing Audiologists (now the Academy of Doctors of Audiology), I described the psychological ramifications of certain contextual factors of an office visit: you and patients focus on a third point (eg, an audiogram); appointments are time-limited and space-limited; a kind of imprinting happens for patients during heightened anxiety associated with diagnostic procedures; and your dialogue satisfies a human need to share a narrative of loss. I explained that, because of these and other factors, audiologists and hearing care professionals have a kind of *transformative power*:

...the ability and means to connect with clients on such a deep, personal level that they share information, their fears, hopes and dreams with you that maybe they've withheld from others. And, at some point, when they begin to trust you and feel safe and comfortable, they take in your warmth and knowledge, follow your recommendations; and, in turn, they experience a change in how hearing loss affects their lives. And because of this change, this transformation, they feel more in control of their world; and they live happier and more productive lives.<sup>5</sup>

An important ramification of these psychological dynamics is that you not only can provide more effective audiological treatment, but you can catalyze profound psychological growth for patients, even though you are not practicing psychotherapy. This may occur precisely because an audiologic visit may trigger post-trauma psychological reactions in patients. In other words, patients often experience a diagnostic procedure as a crisis, replete with increased pulse, anxiety, etc.

When written in Chinese, the word crisis is composed of two characters. One represents danger, and the other represents opportunity. *If, and only if*, the audiologist or hearing care professional sufficiently understands and correctly manages the patient's crisis—post-trauma psychological reactions—then important psychological and amplification opportunities become possible.

For example, Jill was a middle-aged woman who was diagnosed with idiopathic hearing loss and requested hearing aids around the time that her father was diagnosed with terminal cancer. When Dr Smith, an audiologist, asked her the “Why now?” question, her response was short and to the point: “I want to make sure I understand everything my dad’s oncologist says.” Then she added, “We’ve never been close, but I want to try to change that.”

“It’s never too late,” Dr Smith replied.

Jill slowly nodded her head, internally processing his comment, and then they began testing her hearing.

Nothing in Dr Smith’s training taught him to say those simple, comforting words. He didn’t even think about it, as it was a casual comment—seemingly insignificant and inconsequential. He was shocked to learn that his words would echo in Jill’s mind as she sought to repair not only her relationship with her father but also with a host of other relationships that she had neglected. And both he and Jill were shocked when she suddenly began sobbing uncontrollably when he was fitting her with hearing aids.

Later he would understand that, inasmuch as this procedure catalyzed joy and gratitude for her improved hearing, it had also catalyzed post-traumatic flashbacks of scenes that portrayed years of estrangement with her dying father. In her mind, her hearing loss was inextricably connected to her long-term estrangement with her father, his impending death, and to her own mortality.

Although Dr Smith’s personal “therapeutic” feedback (“It’s never too late”) was incidental to the task of diagnosing and treating Jill’s hearing loss, it was *not* incidental to his serving as a catalyst for her psychological growth. He had left a healing imprint that would be forever etched in Jill’s consciousness. Moreover, from then on, it was Dr Smith whom she would go to for new hearing aids and to whom she would refer family members and friends. It wasn’t because of his formal training, expertise, or credibility or even his likeability—although those are important factors of influence, as described by Cialdini<sup>10</sup>; it was because he made a powerful psychological intervention with respect to her post-trauma reactions, albeit without knowing it.

## Psychological Tools in Hearing Care: Respectful Curiosity

**The patient’s reality.** It is essential

to understand how patients construct their reality of the office visit. The phrase “construction of reality” merits elaboration. There is a story about someone who was learning how to be an umpire who asks three umpires for advice. The first umpire says, “I call them as they are.” The second umpire says, “I call them as I see them.” The third umpire says, “They are as I see them.” We are all that third umpire. Zaltman and Zaltman’s research<sup>1</sup> on metaphors harbored by people with hearing loss offers a hearing care professional a glimpse of how an individual patient may construct these realities.

However, it is a common error for practitioners to assume that, because they know how a group of hearing-impaired people frequently construct their reality, that they therefore *ipso facto* know how a particular patient constructs that reality at any particular time. This is analogous to my treating someone from a particular culture and erroneously assuming that, because I know about the person’s culture, I therefore know about him or her as an individual.

Although it is true that by using macro-level research, such as Zaltman and Zaltman’s analysis,<sup>1</sup> you’ll *increase the odds* of matching a patient’s construction of reality (the micro-level), it is important to note that making an error can seriously jeopardize the relationship with a patient and that this macro-level knowledge doesn’t provide guidance to the practitioner on how to interact with a patient, on a step-to-step basis, around his/her construction of reality.

The following examples of clinical errors that I made will clarify these concepts. I was doing marital therapy and the husband was screaming at his wife while turning red in the face. I made what I thought was a safe, rapport-building observation: “You look angry.” However, he indignantly replied, “No, I’m pissed off!” Another example: I was treating a patient for anxiety and used a standard metaphor of “You’re gently floating on water” to facilitate relaxation. However, the patient instantly had a panic attack, as she had almost drown as a child. In both examples, I should not have assumed that because I knew what was true for most people (the macro-level)—a screaming/red in the face = anger, and floating in water = relaxation—that I therefore knew what was true for an individual patient (the micro-level). In each case, I should have asked “Are you angry?” or “Do you find floating water relaxing?”

This relational posture is one of

respectful curiosity. It is critical to achieve a proper balance between:

- 1) Showing curiosity about patients’ realities via questioning, and
- 2) Demonstrating your knowledge and expertise.

Stated differently, we have technical expertise and hypotheses about how patients experience themselves and their worlds (based on research and our clinical experience), but it is important to honor an individual patient as the expert about his/her own thoughts, feelings, and constructions of reality. This is more difficult than at first glance, as it has been my observation that, when we professionals get anxious with patients, we tend to talk more, overly impart our expertise, and become less curious.

Ironically, it may hinder your relationship with a patient if you’re correct when stating how a patient constructs reality or what metaphors a patient uses. Let’s return to Sue, the patient with the high pulse rate who viewed her hearing loss as further evidence that there was something wrong with her. Recall that, apropos of the conflictual relationship with her mother, Sue transferred and projected her feelings of shame onto the unsuspecting audiologist. However, she expended significant effort to hide this anxiety from him, lest he would have too much power to deem her as a “basket case.” Hence, had the audiologist simply laid this all out to Sue, “hitting the nail on the head,” he would probably have caused Sue to bolt from treatment. She would have felt exposed, cornered, increasingly vulnerable, and used words to describe the audiologist like she had used with her mother, such as “know-it-all,” “critical,” etc.

## Two Heads Are Better Than One

So, a patient comes to your office and you have expertise in diagnosing and treating hearing loss. But from there, the terrain gets murky and may be filled with hidden psychological land mines. The patient may be in denial that there is a hearing problem; he or she may request hearing aids but privately not want them; you may be getting into a hidden power struggle with family members, or you may trigger a complex array of post-traumatic emotional reactions. I know little about the audiology part (I wouldn’t know a “pure tone average” if I tripped over it), but I do know a thing or two about dealing with resistance and navigating around psychological land mines that hinder effective care.

What if we team up?

In many cases for providing optimal treatment for people with hearing impairment, two heads—an audiological head and a psychological head—are better than one. There is strong precedent, as psychological collaboration has been proven successful with other service delivery professions. The collaborative health care model,<sup>11</sup> for example, is widely used by physicians who struggle to increase patient adherence to medical recommendations which currently hovers around only 25%.<sup>12</sup> Attorneys collaborate with psychotherapists in order to find ways of helping their clients manage the emotional roller coaster of divorce.<sup>13</sup>

There are several possible logistic arrangements for collaboration. An audiologist may refer a distressed patient to a mental health clinician. However, due to the psychological issues inherent in making a referral, this must be handled very delicately so that the patient does not feel stigmatized or rejected. In another article,<sup>14</sup> I described a detailed, step-by-step procedure for making successful mental health referrals:

- 1) Validate and contain the patient's feelings;
- 2) Normalize (de-stigmatize) the referral;
- 3) Emphasize that optimal treatment of hearing loss necessitates a team approach;
- 4) Humanize the mental health professional;
- 5) Ask permission to telephone the mental health professional in front of the patient; and
- 6) Ask the patient about the status of the referral appointment.

Another option is for an audiologist to receive psychological consultation about ways of navigating around emotional landmines when evaluating or treating their patients. This need is consistent with many doctoral level audiology training programs now including courses on the psychosocial aspects of hearing loss.

Finally, a hearing care professional and a mental health professional may both together and separately meet with the patient at select times during the diagnostic and treatment process. I recall collaborating with an audiologist in this manner and we introduced this approach to the patient as interdisciplinary and holistic audiology—models of care that continue to resonate in our health care industry.

## Conclusion

My rationale for audiology-psychology collaboration may seem self-serving, as I am selling my services to you. Admittedly, this is a valid construction of reality. I recall researching sales techniques while preparing a lecture on Motivational Interviewing and being surprised at their overlap. A colleague remarked, "What took you so long to figure out that trying to motivate people to improve their lives is essentially selling?" He had a point. My surprise had to do with the negative stereotypes that I had of salespeople—a sentiment that I have also often heard from hearing care professionals. Although, we don't attempt to persuade people to make psychological or audiological changes that we judge to be unnecessary, we do attempt to ethically persuade. I try to "sell" people on the advantages of positive self-talk, stress reduction training, esteem-building activities, etc; you try to "sell" hearing-impaired people on ways to improve their hearing and communication. I never wanted to be a salesman but here I am.<sup>15</sup>

Perhaps, per Kochkin's survey,<sup>2</sup> the audiologist-patient interaction is clear cut and relatively "non-psychological" for the less than 1 in 10 people with mild hearing loss and 4 in 10 people with moderate-to-severe hearing loss who agree to use amplification. Those people realize they have a hearing loss and request hearing aids. A done deal. However, this may not be the case for patients who can benefit from amplification but elect not to use it. For this group, the audiologist-patient interaction may be fraught with post-trauma reactions and other psychological landmines for which psychological collaboration would be beneficial.

I conclude this article with an instructive story. A 70-year-old woman said that she finally got hearing aids after many appointments with many different dispensers. I asked her, "Why now?"

She replied, "He was the first person to ask me how I'm doing and who wanted to hear my answer."

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The process of diagnosing and treating one's hearing loss often catalyzes the re-experiencing of painful emotional reactions that had been associated with earlier losses or trauma.