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**Right Product; Right Message: A Cognitive-Behavioral Approach**

*“I’ll never forget when the audiologist asked, “‘You didn’t hear that?’”*

*Even though it was 25 years ago, the impact of that question/statement lingered large.* Barbara felt indicted by the audiologist’s query, and, like many patients, she internalized it as a *traumatic* memory, one which will never extinguish. This kind of trauma is inextricably related to *shame*, Unlike guilt, which is the feeling of doing something wrong, shame is the feeling of being something wrong. Shame is often internalized as “‘there is something basically wrong with me.” It is a pernicious emotion that spawns feelings of inadequacy, inferiority, unworthiness, disgrace, humiliation, and terror.[[2]](#endnote-1) To the extent that the audiology appointment had catalyzed trauma and shame for Barbara, she still dreads such visits, even at the age of 54. She recalled a more recent appointment:

“After a brief catch up on events with my audiologist, I’m seated in the dreaded booth, and the door is shut. No matter how many times I have sat in this seat, I’m still uncomfortable. After all it is a test. *One for which I hopefully have studied properly.*

“My hands feel clammy when I grasp the ‘Push Me’ Button when I hear the tone. For that brief instant before the first ‘note,’ I envision a scene from Alice in Wonderland when Alice has fallen down the rabbit hole and is confronted with a dilemma and a ‘Drink Me’ potion. It’s a scene based on trust before stepping into the unknown.”

On a rational level, Barbara knew the hearing test was not something for which she had to study (she has a doctorate in Education). She knew it wasn’t an issue of passing or flunking; and it certainly had nothing to do with her competence. But human beings aren’t always rational.

Moreover, the experiences of trauma and shame by many patients echo what Beck and Alcock termed “an underlying social norm which views hearing healthcare (at best) as generally irrelevant and (at worst) as a threat.”[[3]](#endnote-2) Beck and Alcock attributed the widespread negativity associated with hearing aids to HHPs (Hearing Health Professionals) offering the *right product- but with the wrong message*:

“Traditionally, HHPs have invited people to discover they have a ‘condition’ or a hearing impairment, while detailing how bad their condition is (i.e., how flawed the person is) while pointing out the negatives (i.e., ‘these are the sounds you can’t hear…’). HHPs subsequently offer a solution (hearing aids) that is often unexpectedly expensive and may come loaded with negative associations attached to it.”

To the extent that a person with hearing loss has internalized negative social norms, a “traditional” audiology visit is likely to trigger shame-based self-evaluative cognitions.*[[4]](#endnote-3)*  For example, “I didn’t study properly for the hearing test, therefore I’m unworthy”; “I’m falling into the rabbit hole.” Barbara quickly defended her audiologist with me by interjecting that “She was very nice and her voice wasn’t critical like ‘You didn’t hear that? ‘and obviously, she needed to evaluate what I couldn’t hear! She had to ask questions.”

Barbara was correct in that the audiologist needed to evaluate her hearing and ascertain what she couldn’t hear. However, Barbara’s hearing evaluation did not need to trigger trauma and shame.

The subject of this article is what audiologists can do to 1) minimize a patient’s trauma and shame which may be triggered by a hearing evaluation and 2) “make lemonade out of lemons”: actually utilize patients’ emotional reactions as opportunities for better collaboration and their emotional growth.

Specifically, tools from *Cognitive Behavior Therapy (CBT)* can be appropriately utilized by hearing healthcare professionals while remaining within their professional boundaries. This approach can set the stage for patients to excavate and examine their negative self-evaluative cognitions – “self-talk” – and modify irrational cognitions such as “I need to study for the hearing test.” Left unexcavated and unexamined, they become psychologically toxic and significantly impede a patient’s receptivity to hearing healthcare.

Cognitive Behavior Therapy is based on the concept that the way we think about things (e.g. hearing loss) affects how we feel and how we behave (e.g., accept hearing aids). In a nutshell, patients can be helped to become aware of their internal conversations (“self-talk”) about hearing loss, and to distinguish the positive, rational thoughts from the negative, irrational thoughts, and finally, to replace the irrational, so-called “cognitive distortions” with rational thoughts.

For example, a common “cognitive distortion” is polarized, all or nothing thinking. “I have to be perfect or I’m a failure — there is no middle ground.”[[5]](#endnote-4) In the case of persons with hearing loss, this distortion takes the form of “My hearing isn’t perfect, therefore I’m defective, broken, and a failure, and hearing aids are a concrete symbol of my failure status – a “Scarlet A” of sorts. This cognitive distortion is the essence of shame. The task – for the patient and the audiologist and/or psychotherapist – is to identify these cognitions as irrational, and replace them with more rational cognitions, such as “I have at least 1001 things that are working perfectly in my body: legs, arms, pituitary gland, spleen, etc., etc. The only thing that isn’t working properly is some of my hearing. To be worthwhile, I don’t have to be thoroughly competent, adequate, and achieving in all possible respects.”

Step 1: Begin where the patient is at*.* At the outset, it is critical to at least briefly elicit from your patient which societal negativity about hearing healthcare they have internalized, and to convey an appreciation and validation for how they feel. Human beings crave to be understood. Indeed, this is the prerequisite for behavioral change. Of note, well-timed and mutually enjoyable humor helps foster relationship building.

Pt: “It’s not my ears. My wife mumbles.”

Audiologist: “Wow, you’re the ump-teenth person who’s told me this. It must be an epidemic!” (smiles)

Pt: (smiles)

Audiologist: “Yeah, many people get the message that having trouble hearing is something to be ashamed of, and they’re afraid of flunking the hearing test, like flunking a final exam. Is that kinda how you feel?”

Pt: “Yeah, that’s me.” (nods his head).

Step 2: Educate patients that they have internal conversations going on in their head that influence their feelings and behavior A basic CPT principle: Thoughts Feelings Behavior. An illustrative story is often helpful. For example, a husband wanted to surprise his wife with flowers. However, when he gave her the dozen roses, she became furious and threatened to end their marriage. Why? She thought the flowers were her husband’s way of assuaging his guilt for having an affair. Her thought led her to feel angry which, in turn, lead her to threaten divorce.

Pt: “I try not to join conversations because I would only fail. It makes me look stupid.”

Audiologist: “If you continue choosing to think that evidence of hearing loss makes you look stupid, what will you then feel?”

Pt: “Embarrassed, inadequate . . . “

Audiologist: “And then what will you do?”

Pt: “Stay at home and make myself a good stiff drink.”

Audiologist: “Your thoughts wield a lot of power, huh?”

Pt: “Yeah, they sure do.”

Step 3: I think, therefore I am. Emphasize that as human beings, we have the ability to choose what we think. The wife *could have* decided to think her husband brought her flowers because he loved her. As author Toni Morrison put it, You wanna fly? Then you’ve gotta give up the stuff that weighs you down.”[[6]](#endnote-5) Holly Elliot noted, with respect to her hearing loss, “Shifting gears is a process by which we choose change. Now that may seem crazy because we sure didn't 'choose' hearing loss. But we can choose how we manage it.“[[7]](#endnote-6)Audiologists can *offer* clients educational material on cognitive behavioral principles. Note the critical importance of offering, of asking patients for permission to give reading material. Particularly for persons who have incurred major losses and experience limited control, it is important to honor what control they do have.

Audiologist: “Your decision about what to think is the key! Many people with hearing loss discover they’re thinking tons of thoughts they’re not even aware of, and that causes them to feel lousy about themselves and hearing aids. Are you curious about this?”

Pt: “I guess.”

Audiologist: “Could I give you some bedtime reading material and maybe get your reactions to it next time we meet?

Pt: “Sure.”

Step 4: Suggest alternative, rational cognitions. At first glance, this step may appear to cross a professional boundary by attempting to practice psychotherapy. Indeed, as one audiologist stated: “We’re trained to counsel about causes and effects of hearing loss, treatment options, communication strategies, etc. I'm not convinced we should be significantly involved in the counseling process beyond the informational level. You can only wear so many hats.” However, as I elaborated in a previous publication, patients are likely to disclose sensitive, shame-based, cognitions/feelings to audiologists that they may not even share with therapists, precisely because the context triggers traumatic, hearing loss-related memories and affective reactions.[[8]](#endnote-7) The question is how to respond.

Let’s return to Barbara. Recall her reporting clammy hands, her vision of Alice falling down the rabbit hole, and fears that she would flunk the hearing test. Although it would have violated professional boundaries for her audiologist to have delved into her past experiences of shame or conducted intense exploration of her feelings – *that* would be wearing “two hats” – Barbara’s palpable anxiety and shame represented important opportunities for the audiologist to have offered her an alternative way of thinking, to *reframe* her hearing loss and hearing healthcare.

Barbara: “This is so pitiful!”

Audiologist: “May I ask what you’re thinking that causes you to feel that it’s so pitiful?”

Barbara: “I can’t hear so many of the tones, so I’m remembering many times that I’m in unfamiliar professional or social situations and I get so anxious that people will think less of me because I’m either not answering them or I’m responding inappropriately to what I’m guessing they’re saying. I’m embarrassed because I look stupid.”

Audiologist: “If people think less of you or they think you’re stupid, you think you’re pitiful and stupid?”

Barbara: “Something like that.” (She looks down and shakes her head.).

Audiologist: “Many people with hearing loss tell me that they fall into the trap of thinking like that. It’s not only you. Did the reading I gave you give you any ideas about how you can decide to change your thoughts about this?”

Barbara: “Hmmm.” (produces the article). “Yeah, I can choose not to subscribe to what’s called ‘emotional reasoning’: the belief thatwhat we feel must be true automatically is true; that if I feel stupid, then I must be stupid, and other people will view me as such. I can also stop ‘*catastrophizing’* about the possibility that people think I’m stupid. While it would be swell if everybody thought I was real smart, that’s not a necessity for me to remain alive and be happy. I have a core group of family and good friends who are affirming and I do care about what they think. Finally, even if some people really think I’m stupid, their approval isn’t necessary for my survival. I need to stop what has been called ‘MUSTerbating in public’: holding on to the belief that people MUST approve of me, MUST like me; MUST think I’m smart.[[9]](#footnote-2) If some people think I lack intelligence because I can’t hear certain things, it’s because *they’re* pitiful, not me!”

Audiologist: “Go for it! You look stronger!”

Barbara: (big smile). “Yeah, I’m going to discuss this more with Dr. Smith.”

The audiologist had referred Barbara for psychotherapy with a therapist, “Dr. Smith,” as this is often a useful adjunct to audiologic care. An important caveat: it frequently important to describe psychotherapy *as skills training,* as this reframe reduces its stigma. It is far more preferable to go to a therapist because “I want to acquire some tools” rather than because “I’m nuts.”

Step 5: Create an association between hearing healthcare and rational thoughts. I often tell patients that on my computer, I create associations between certain files and software so that the files open with the correct software, and that if I don’t do this, I cannot take full advantage of my 64-bit operating system with 2.70 GHz processor and 8.0 GB of RAM. Then I make the analogy explicit: “Similarly, you can create an association between hearing/listening tools and rational thoughts in order to take full advantage of your power and capability.” I may reframe hearing aid amplification as “an acoustic magnifying glass of sorts.” Motivational Interviewing techniques may be helpful at this juncture.[[10]](#endnote-8)

It is essential that patients experience heightened self-esteem and pride – the opposite of shame – by embracing hearing healthcare and therefore getting more of what they value. I often share with patients a story of a man with multiple sclerosis who had great difficulty walking but wouldn’t use a wheelchair because it was intolerable to him that people may pity him, that is, until he wanted to visit a museum exhibit that was surrounded by cobblestones. It was only then that he decided to “connect” his using a wheelchair to rational thinking: “I deserve to honor my wants and needs rather than remain subjugated by my belief that what people may think is so damn important.”

It is often helpful for patients to script their internal discussions or debates between their rational and irrational cognitions, or messages. The audiologist may “role play” the wrong message while the patients argues for the right message; hence, the patient is stating the arguments for positive change which often increases motivation. And/or the patient can role play both sides of the debate.

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This article is a micro-level analysis of how audiologists can help patients *deconstruct their* hearing loss; that is, tease it apart from long lists of “wrong messages” -- stigma, shame, embarrassment, etc. This would be an easier task if, as Beck & Alcock suggest in their macro-level analysis, “. . we all become committed to establishing a new social norm in hearing care—one that focuses on ‘maximal hearing and listening’”; reaping the benefits of no longer missing what you’d like to hear; of getting more of what you want.[[11]](#endnote-9)

I asked Barbara what might have been different about her hearing test 25 years ago if that social norm prevailed. She responded immediately: “The audiologist would still have asked me all those questions, but I would have felt that she was going to help me, not flunk me.

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2. Sorenson, M. *Breaking the Chain of Low Self-Esteem, 2nd edition*. Portland, Oregon: Wolf Publishing Company; 2006 [↑](#endnote-ref-1)
3. Beck, D.L & Alcock, C. J. Right product; wrong message. *Hearing Review. 2014: 21(4), 16-20.*  [↑](#endnote-ref-2)
4. Harvey, M.A. What your patients may not tell you: combating deep metaphors and the rationale for audiological-psychological collaboration. *Hearing Review, 2010;* 16-20. [↑](#endnote-ref-3)
5. Burns, D. D. [*The feeling good handbook, revised*. New York, NY: Plume Publishing; 1999.](http://www.amazon.com/Feeling-Good-Handbook-David-Burns/dp/0452281326)  [↑](#endnote-ref-4)
6. Morrison, T. *Song of solomon*. New York, NY: 1977. [↑](#endnote-ref-5)
7. #  Elliott, H. *Teach me to love myself: memoir of a pioneering deaf therapist*. Amherst, MA: White River Press; 2008.

 [↑](#endnote-ref-6)
8. Harvey, M.A. What your patients may not tell you: combating deep metaphors and the rationale for audiological-psychological collaboration. *Hearing Review, 2010;* 16-20 [↑](#endnote-ref-7)
9. This is a well-known therapy phrase that was coined by Albert Ellis, who developed Rational Emotive Therapy. [↑](#footnote-ref-2)
10. Beck D. L., Harvey M. A., and Schum D. J. Motivational interviewing and amplification. Hearing Review, 2007: 14(11), 14-20. [↑](#endnote-ref-8)
11. Beck, D.L & Alcock, C. J. Right product; wrong message. *Hearing Review. 2014: 21(4), 16-20.*  [↑](#endnote-ref-9)