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Letter to the Editor

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Considerations from Psychology on Implementing Motivational Interviewing in Audiology: Response to Solheim et al (2018) "An Evaluation of Motivational Interviewing for Increasing Hearing Aid Use: A Pilot Study"

The September 2018 *Journal of the American Academy of Audiology* article, "An Evaluation of Motivational Interviewing for Increasing Hearing Aid Use: A Pilot Study" (Solheim et al, 2018) presents an effort to explore how motivational interviewing (MI) can be used in audiologic practice to increase hearing aid wear time for patients. In this study, participants (N = 47) demonstrating an average hearing aid wear time of <90 minutes per day at six months postfitting were provided with one 30-minute session of MI. Three months after the MI intervention, average hearing aid wear time was measured (data logging), and participant experiences with hearing aids was explored. The purpose of the study was to determine if MI had a significant effect on data logging and participant perception of hearing aids.

MI is a counseling method to help patients draw on reasons or motivations for seeking treatment, exploring feelings of ambivalence (e.g., recognizing the need for hearing aids but not wanting to wear them), and changing behavior (Rollnick et al, 2008). Through purposeful dialogue, audiologists use MI to help patients work through barriers they are experiencing that prevent adequate use of amplification technology. MI is an empirically supported psychotherapy, and other areas of healthcare have successfully used MI to support desired behavior change to increase treatment adherence (Rubak et al, 2005). Solheim et al (2018) is one of the first studies to investigate MI in audiology, an important and needed area of research that has the potential to advance hearing healthcare and improve patient outcomes.

For MI to be effective in supporting patient behavior change, there are important considerations for how MI is implemented. First, recognition of MI as a form of communication to elicit patient barriers or concerns through listening, asking, and informing is critical (Rollnick et al, 2008). MI is a style of communication that can be woven into provider–patient interactions rather than an adjunctive intervention component. Second, behavioral change may take significant time to occur, and MI should be implemented in a way that allows time for providers to explore patient ambivalence, collaborate with and elicit change talk from patients, reduce patient resistance, build trust, and increase patient self-efficacy (Hettema et al, 2005). From an MI framework, patients are conceptualized as going through stages of change: precontemplative, contemplative, preparation, action, and maintenance. The duration of each stage can range from days to months, and patients do not necessarily proceed through them in a linear fashion (Norcross et al, 2011). Because a core feature of MI is tailoring intervention to stage of change, MI typically occurs over a period of months and even years. Through purposeful MI, providers guide—rather than direct—patients through problem-solving and effective behavior change at the latter's pace.

Solheim et al (2018) procedures for MI delivery may provide clinical audiologists with the impression that MI can be used as a secondary one-time intervention appended to the technical aspects of an audiologic appointment, as demonstrated by the study's use of a technical audiologist to handle programming changes and an educational audiologist to counsel through MI separately. Given that an MI approach is more similar to a marathon than a sprint, it is imperative that studies testing such interventions account for the time it requires for behavioral change to occur—especially when patients are in the precontemplative or contemplative stage of change. Furthermore, the way Solheim et al (2018) used MI to emphasize the positive aspects and benefits of hearing aid use is not fully adherent to MI's intentional avoidance of the "righting reflex," which is the provider's tendency to tell patients why they need to change their behavior and provide provider-centered solutions (Rollnick et al, 2008). We could improve this by guiding patients toward understanding the need for change on their own and letting them establish patient-centered solutions (Rollnick et al, 2008). At its core, MI requires the provider to meet the patient where they are at in their motivation to change.

MI is a counseling strategy that has been increasingly accepted as a tool for behavior change and can be effectively used by any clinical professional, including audiologists. We agree with the authors that MI can be an effective tool to promote increased device use in patients with hearing loss. To provide empirical evidence for the effectiveness of MI in audiologic practice, a clear understanding of how to incorporate MI into audiologic appointments is needed. Some suggestions for future studies evaluating the effectiveness of MI in audiologic appointments could be to provide clear fidelity controls to ensure appropriate implementation, including protocols for MI training, to guard the integrity of MI-based interventions, and to accurately assess the

utility of incorporating MI into audiologic sessions. Finally, future attempts at such studies will likely have stronger outcomes if MI is incorporated as designed by considering the patient's current stage of change and allowing time (more than one 30-minute session) for progression through each stage based on the patient's motivation.

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