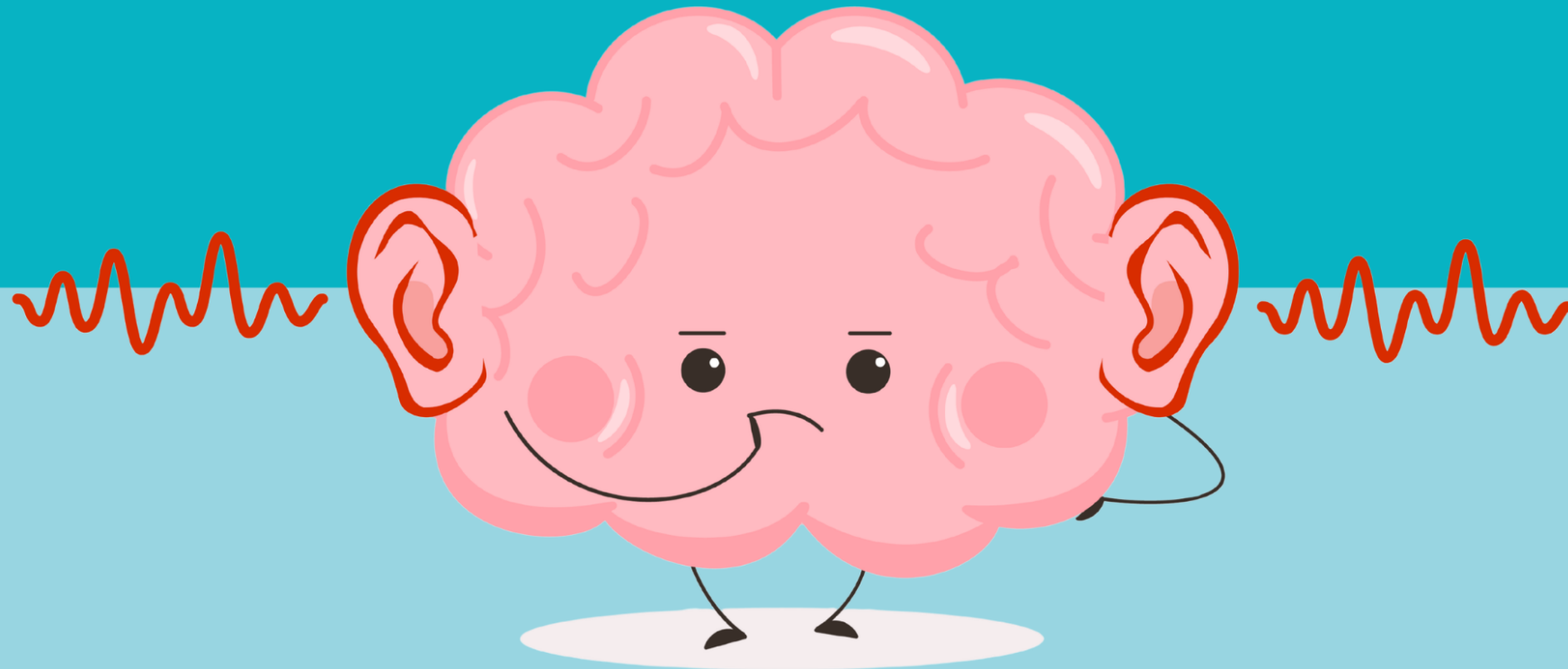


WHY TRAUMA INFORMED CARE BELONGS IN AUDIOLOGY: Mental Health & Hearing Loss



PRESENTED BY: Abigail Sweeney, Au.D., M.A., LPC-A

WHAT WILL YOU LEARN?



- Explain the relationship between hearing loss and mental health, including prevalence and emotional impact, and why trauma-informed care belongs in audiology.
- Recognize emotional barriers in hearing care and use trauma-informed strategies that support trust, communication, and patient choice.
- Apply the H.O.P.E. Hearing Method and motivational interviewing (MI) skills to explore patient concerns, identify meaningful goals, and support informed decisions.

THE ROAD THAT BROUGHT ME HERE...



oticon



Heal Orient Process Emerge
With Jesus at the center we care for body, mind, and spirit so you can heal, orient toward hope, process your story safely, and emerge whole and at peace.
Empowering your journey to HOPE beyond the HURT.

HEARING LOSS & DEPRESSION



- HL reduces patient ability to socially engage.
- Social isolation associated with HL is a major contributor to late life mental health problems, including depression.
- What % increase in risk of depression do we see in older adults?

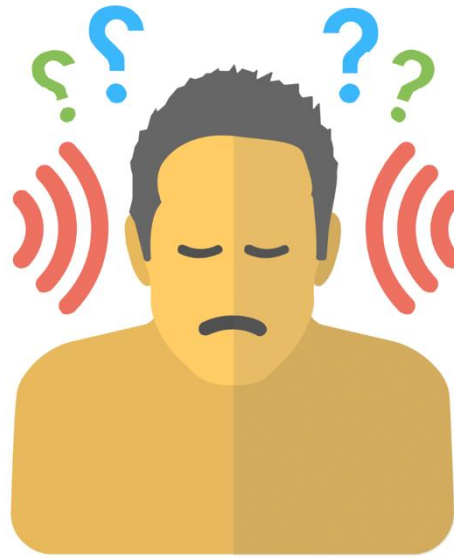
47%

- Depression is 2x more likely in the hearing impaired population compared with normal hearing individuals.

THE EMOTIONAL LOAD OF HL



Isolation



Increased Listening
Effort

Exhaustion



Difficulty
Remembering things

HEARING LOSS & ANXIETY



AS HEARING LOSS PROGRESSES ANXIETY INCREASES



- Mild HL = 32% increased chance of anxiety
- Moderate HL = 59% increased chance of anxiety

COMMON SOURCES OF HEARING LOSS ANXIETY

People are
judging me.

...?

...



COMMON SOURCES OF HEARING LOSS ANXIETY

People are
judging me.

I'm
becoming
isolated.

...?

...



COMMON SOURCES OF HEARING LOSS ANXIETY

People are
judging me.

I'm
becoming
isolated.

I'm a
burden to
others.

...?

...



COMMON SOURCES OF HEARING LOSS ANXIETY

People are
judging me.

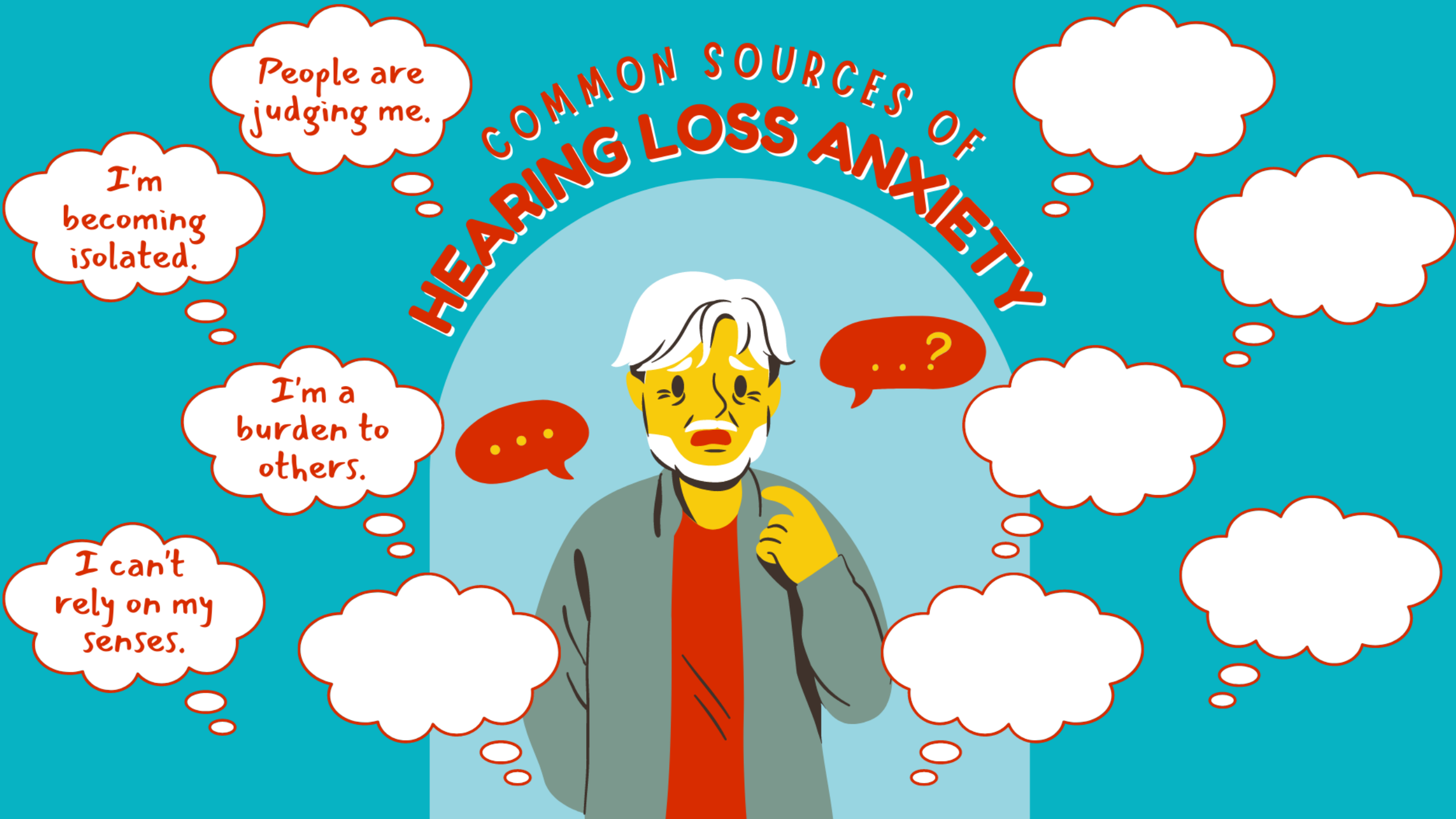
I'm
becoming
isolated.

I'm a
burden to
others.

I can't
rely on my
senses.

...?

...



COMMON SOURCES OF HEARING LOSS ANXIETY

People are
judging me.

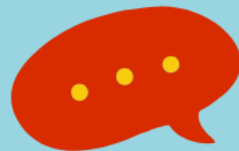
I'm
becoming
isolated.

I'm a
burden to
others.

I can't
rely on my
senses.

I'm losing
control.

...?



COMMON SOURCES OF HEARING LOSS ANXIETY

People are
judging me.

I'm
becoming
isolated.

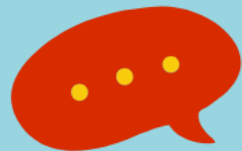
I'm missing
important
information.

I'm a
burden to
others.

I can't
rely on my
senses.

I'm losing
control.

...?



COMMON SOURCES OF HEARING LOSS ANXIETY

People are
judging me.

I'm
becoming
isolated.

I'm missing
important
information.

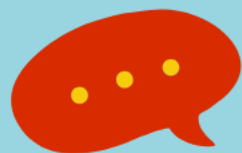
I can't
participate
fully.

I'm a
burden to
others.

I can't
rely on my
senses.

I'm losing
control.

...?



COMMON SOURCES OF HEARING LOSS ANXIETY



People are
judging me.

I'm
becoming
isolated.

I'm a
burden to
others.

I can't
rely on my
senses.

I'm losing
control.

I'm missing
important
information.

I can't
participate
fully.

What if my
hearing
worsens.

...?

...

COMMON SOURCES OF HEARING LOSS ANXIETY



People are judging me.

I'm becoming isolated.

I'm missing important information.

I can't participate fully.

I'm a burden to others.

I can't rely on my senses.

I'm losing control.

What if my hearing worsens.

My relationships are affected.

COMMON SOURCES OF HEARING LOSS ANXIETY



People are judging me.

I'm becoming isolated.

I'm a burden to others.

I can't rely on my senses.

I'm losing control.

I'm missing important information.

I can't participate fully.

What if my hearing worsens.

I can't enjoy certain activities anymore.

My relationships are affected.

...?

...

When the Past Enters the Appointment

Present struggles



Earlier experiences



One person. A whole story.

Past experiences and present struggles may meet in the audiology visit.

WHAT IS TRAUMA?



Think of trauma as an emotional wound.

Lasting effects of experiences that felt harmful or threatening.



A small cut



A deeper wound

Different wounds. Both deserve care.

BIG “T” VS. little “t”



Big “T”

1. Physical or Sexual Abuse
2. Natural Disasters
3. Combat or War
4. Serious Accidents
5. Terrorist Attacks
6. Kidnapping or Hostage Situations
7. Severe Medical Events
8. Sudden Loss of a Loved One
9. Sexual Assault
10. Childhood Abuse or Neglect

Little “t”

Hearing-related examples

1. Chronic Emotional Neglect
2. Repeated Humiliation or Rejection
3. Microaggressions
4. Unhealthy Relationship Dynamics
5. Bullying or Teasing
6. Being Mocked for Mishearing
7. Being Left Out of Conversations
8. Impatience When Asking for Repetition
9. Having Hearing Needs Dismissed
10. Being Treated as Less Capable

Informal teaching terms—not diagnostic categories. These examples do not rank whose pain matters.
Painful experiences may have lasting effects; not every experience results in trauma.

WHY TRAUMA IMPACTS PEOPLE DIFFERENTLY



What happened before, during, and after?

Before

- Earlier experiences
- Existing resources and support
- Personal circumstances

During

- Degree of threat
- Fear or helplessness
- How the event was experienced

After

- Support and connection
- Ongoing stress
- Opportunities for recovery

WHEN THE PAST FEELS IN THE PRESENT



Earlier loss of choice



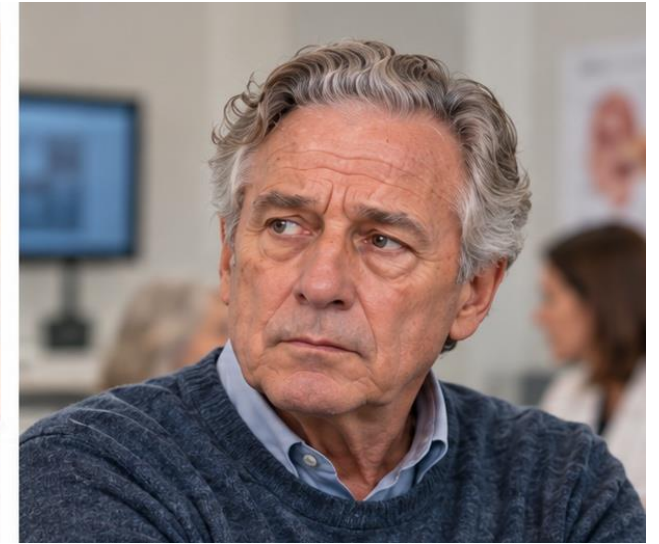
A controlling father.
Little choice. Felt powerless.

Feeling overruled today



Wife and clinician discuss options.
“They’ve decided for me.”

A possible response

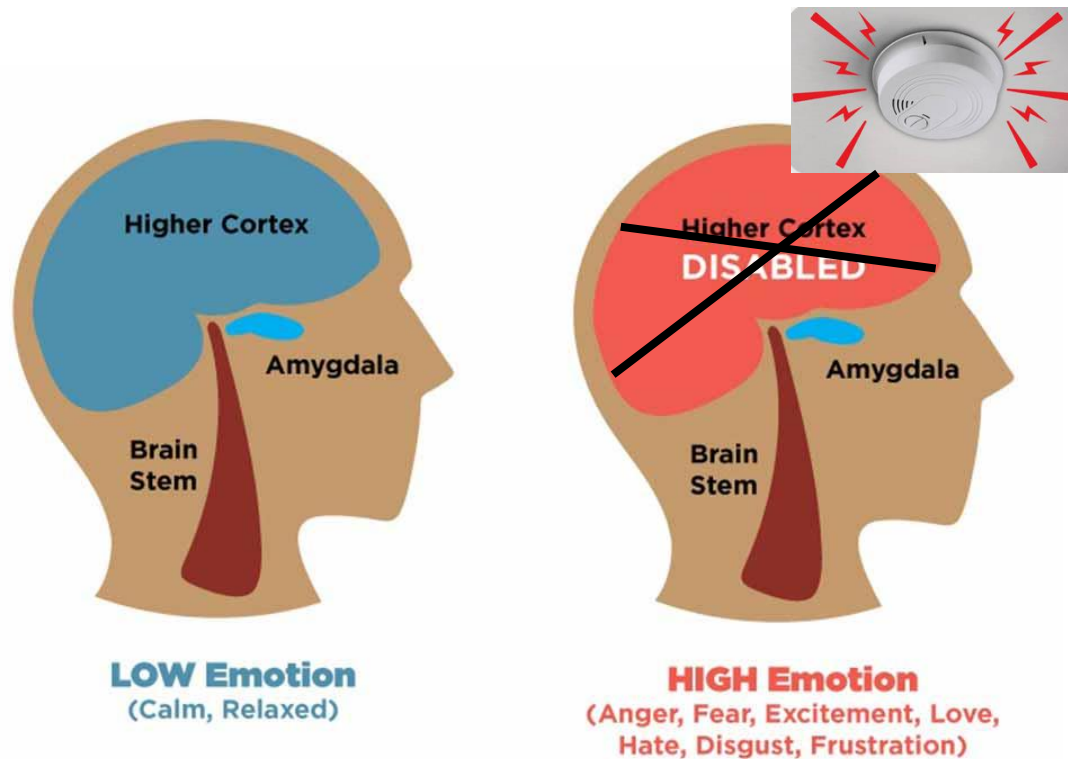


“I’m not getting hearing aids.”
Stops engaging.

THE STRESS RESPONSE



Under significant stress, the brain may prioritize protection.



Prefrontal cortex (PFC)*

“Thinking brain” – Attention, working memory, and flexible thinking can become less effective.

*The PFC is the *Higher Cortex* in this diagram

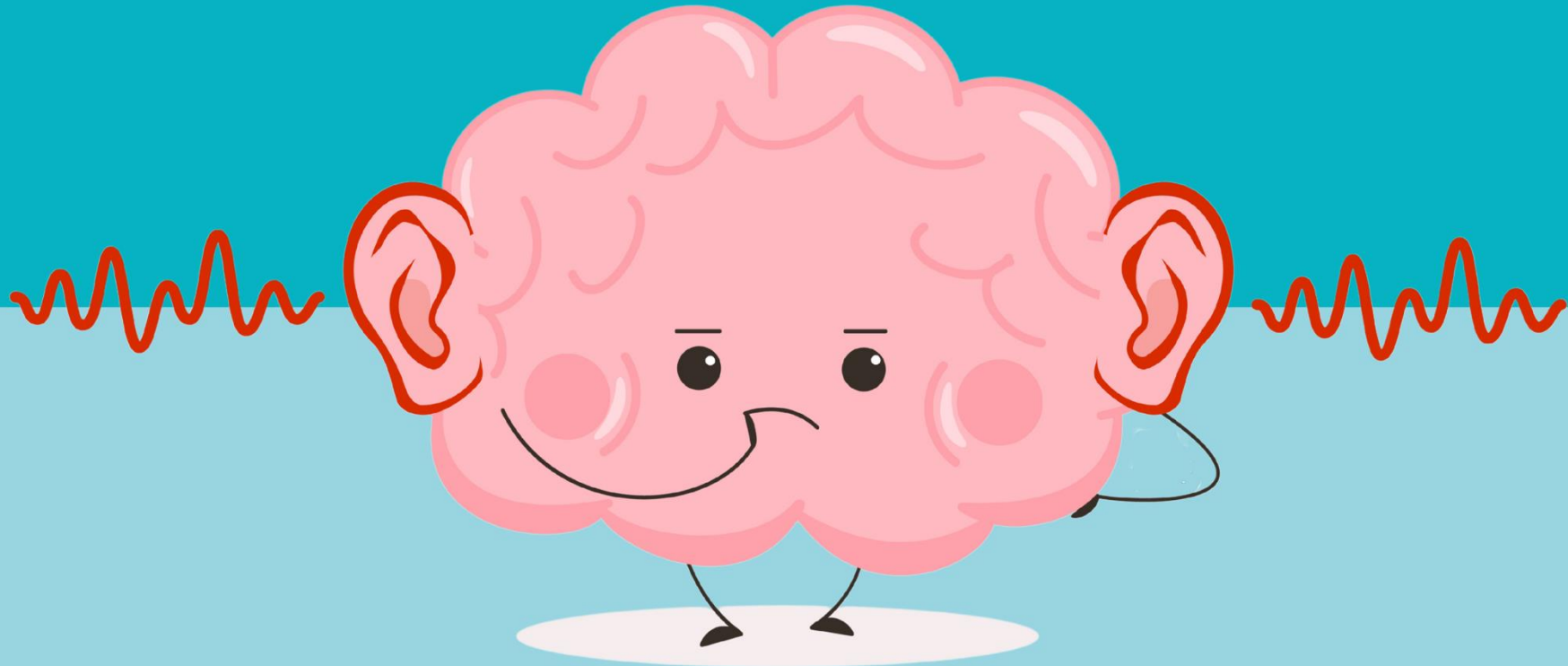
Amygdala

“Survival brain” – Activates when a threat is perceived and PFC becomes less effective under stress

A slower pace and clear choices can support participation.

WHEN PATIENTS HESITATE

*Understanding concerns before
responding*



PATIENT RESISTANCE



- Resistance—we expect or push for change when the patient is not ready for that change
- Patients who have mental health concerns are more likely to exhibit resistance which means they are less likely to change.

PATIENT RESISTANCE



Pause. Get curious. Understand the concern.

REASONS FOR RESISTANCE TO HEARING AIDS



AFRAID OF COST



EMBARRASSED
FEAR OF

FEAR
FEAR
FEAR



FEAR OF CHANGE



NEGATIVE
OVERTONES

PATIENT RESISTANCE IN HEARING HEALTHCARE



55%

BASED UPON A NATIONAL
AVERAGE HELP RATE OF

45%

HOW TO RESPOND TO PATIENT RESISTANCE?



MOTIVATIONAL INTERVIEWING (MI)



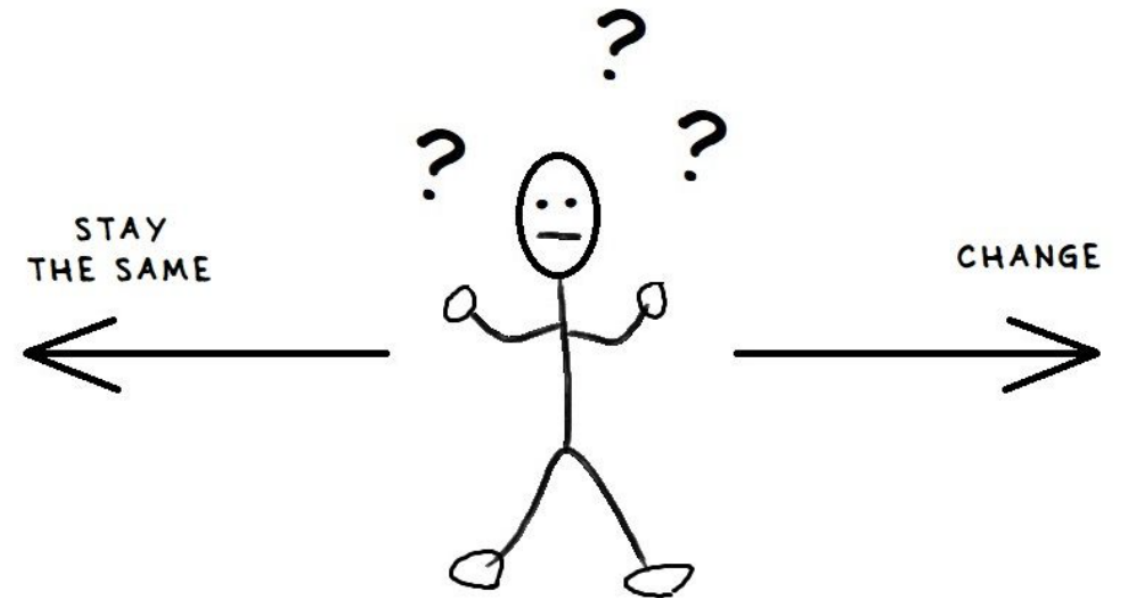
- Motivational interviewing is a trauma-informed counseling method that helps people resolve **AMBIVALENT** feelings and insecurities to find the internal motivation they need to change their behavior.
- Introduced by psychologist William R. Miller in 1983 – original focus was working with addicts.
- “The more you try to insert information and advice into others, the more they tend to back off and resist. MI involves coming alongside the person and helping them to say why and how they might change for themselves.” (Stephen Rollnick)

AMBIVALENCE

- Ambivalence is simultaneously wanting and not wanting something.
- Ambivalence is a good thing because there is actually motivation to change within the patient.
- Patients who are ambivalent will exhibit both change talk and sustain talk – that is the wanting and not wanting something at the same time.



AMBIVALENCE



CHANGE VS. SUSTAIN



- Change Talk

“
I NEED TO DO
SOMETHING ABOUT
MY HEARING LOSS
”

- Sustain Talk

“
I HATE THE THOUGHT
OF PEOPLE NOTICING
MY HEARING AIDS.
”

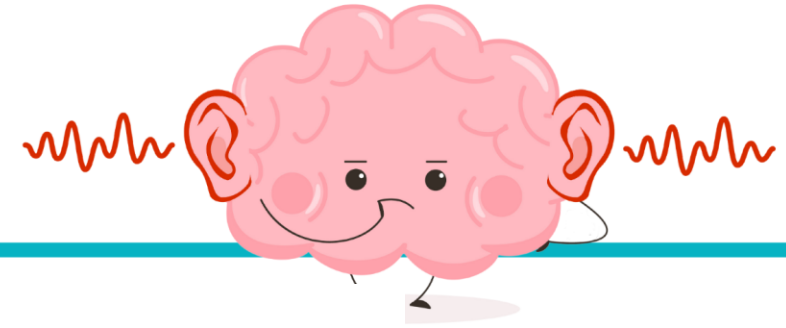
RIGHTING REFLEX & PERSUASION



- Our natural tendency when someone exhibits ambivalence is to try and persuade them to change. Or we may use the righting reflex which is trying to “right them” when our opinions differ.
- If you are using the righting reflex or trying to persuade the patient, you will fight for the patient to get hearing aids. The patient will then try and convince you why they don’t need hearing aids right now.
- In order to strengthen a person's motivation for change, we must have a conversation with the patient and allow them to explore his/her motivation to change within an atmosphere of acceptance and compassion.



MI THEORY

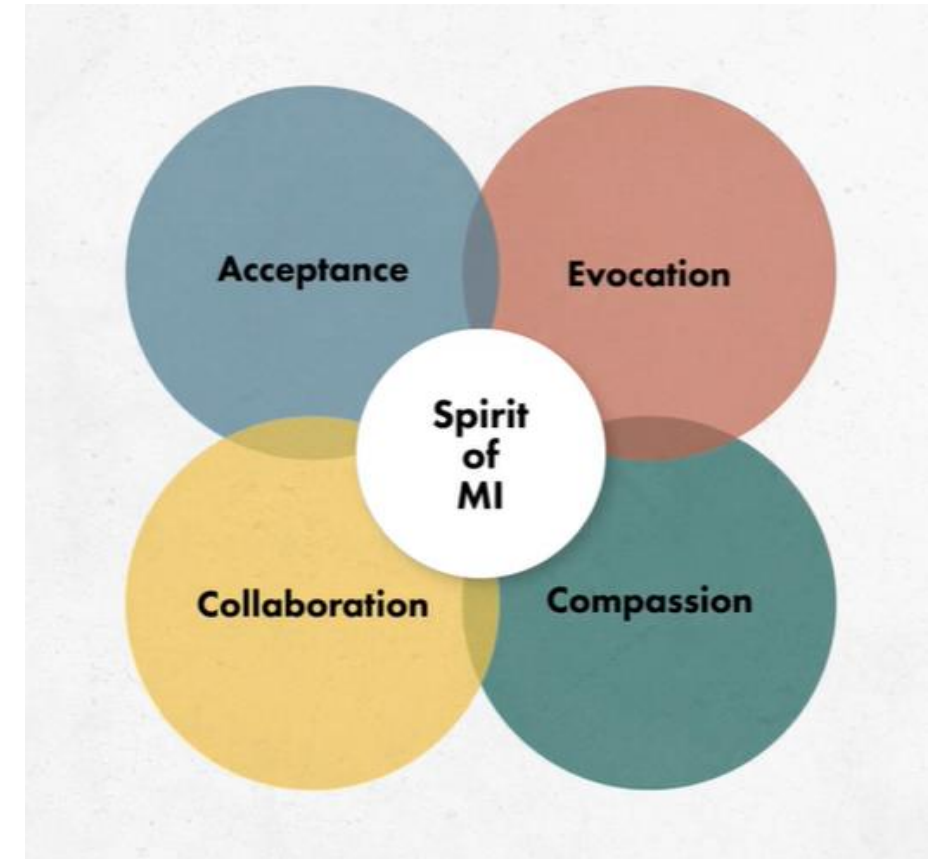


**STRONGEST MOTIVATIONS
FOR BEHAVIORAL CHANGE
ARE THE ONES PATIENTS
DEVELOP FOR THEMSELVES.**

SPIRIT OF MI



- You can ask the right questions, but if you don't have the spirit of MI you will not be successful in using this technique.
- Part of the spirit is **CURIOSITY**. If you don't ask the right question or your technique is off a bit, but your spirit of curiosity and helping someone is there, you will still be successful.
- If someone says "No" to you, it is likely because you did not exhibit the spirit of MI.



4 PROCESSES IN MI



1

ENGAGING

Building an alliance and a working relationship with your client



3

EVOKING

Bringing out the clients own arguments for change



2

FOCUSING

Coming to a shared idea about the main focus.



- In Audiology, the focus is easy 😊

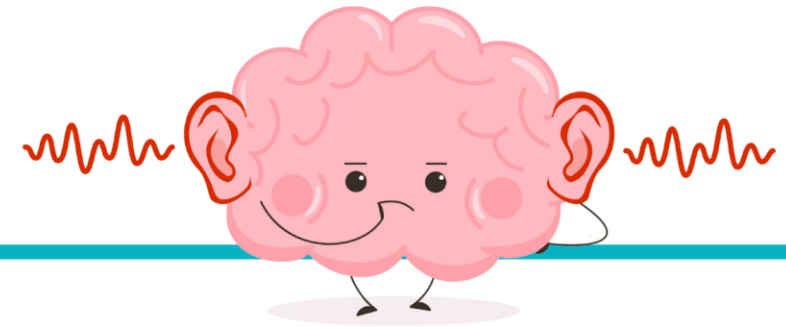
4

PLANNING

The client is willing to envision change and how they go about making it



ENGAGING IS YOUR 1st IMPRESSION

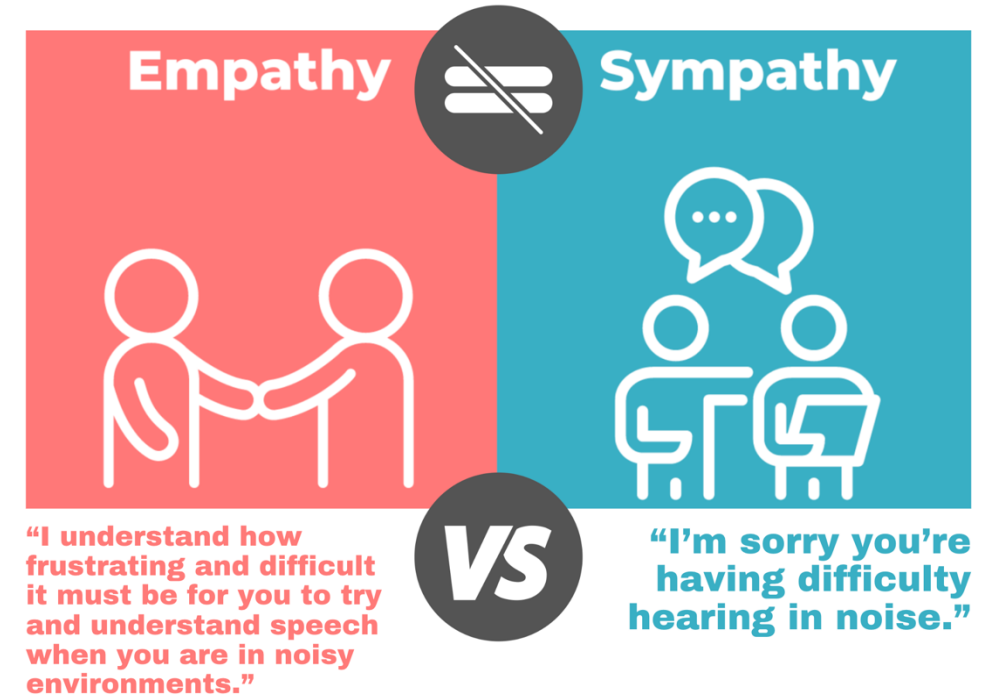


Providers get better at engaging when they get better at listening, recognizing strengths & emphasizing autonomy.

ENGAGING = EMPATHY IS KEY!



- To engage well, you must get good at empathetic listening.
- Empathetic listening is a 2 step process:
 - (1) listening/capturing
 - (2) handing it back.
- It's a very active process that requires you are fully listening and not distracted at all.





EMPATHY USING THE OARS MODEL



The OARS Model



OPEN-ENDED QUESTIONS

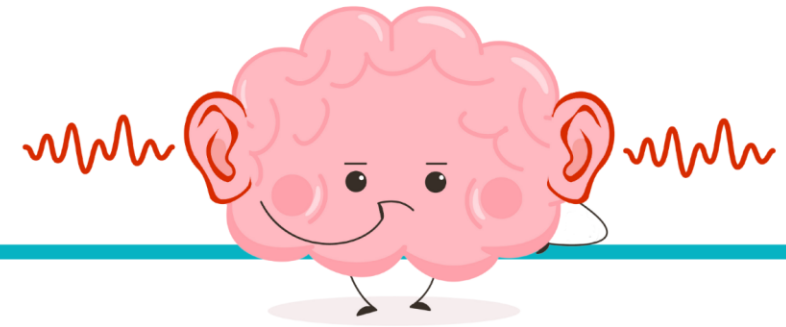
AFFIRMATIONS

REFLECTING LISTENING

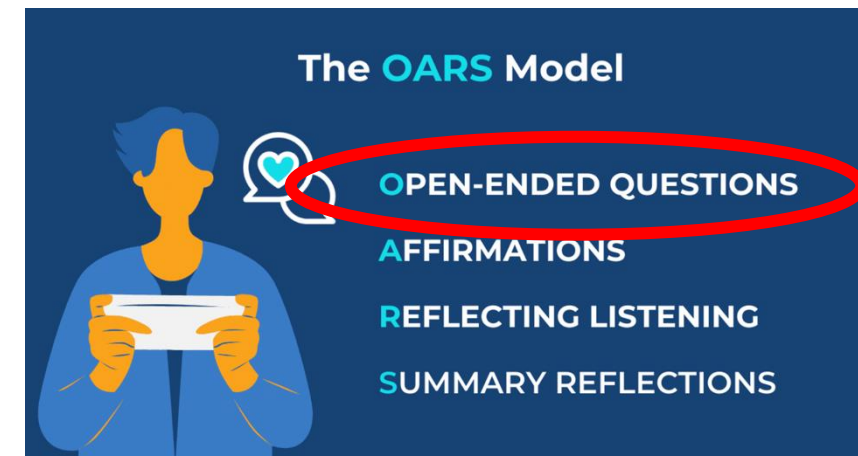
SUMMARY REFLECTIONS

Core set of four foundational communication skills used within MI to build rapport, resolve ambivalence, and support behavior change

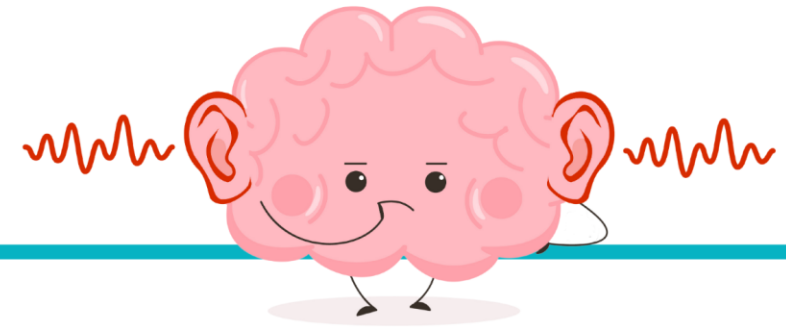
O=OPEN ENDED QUESTIONS (OEQ)



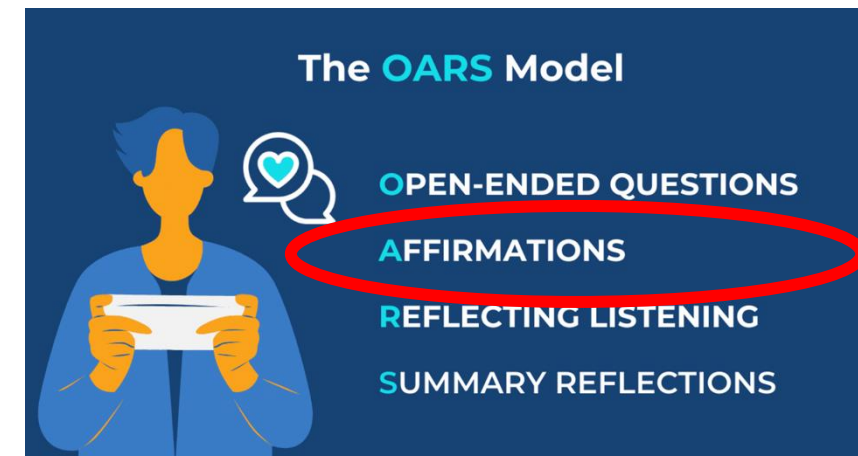
- OEQ are designed to encourage a more meaningful, detailed answer from a patient using his or her own knowledge and/or feelings.
- These can often elicit unanticipated information and help you guide the appointment.
- Examples:
 - “How can I help you?”
 - “What are the positives and negatives of amplification?”
 - “What are your goals today?”



A=AFFIRMATIONS



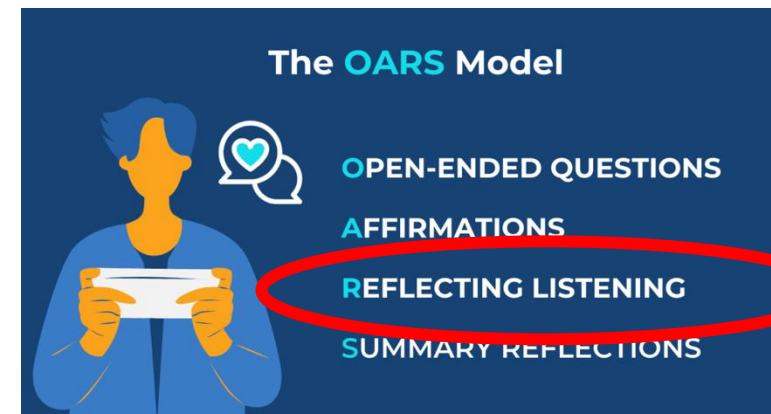
- An affirmation is something encouraging or reassuring or some strength of your patient that you notice and reflect it back to them.
- Affirmations help the patient not view themselves as “disabled”.
- Simple Affirmations
 - “Good for you”, “Thanks for being here”, “That’s great”
- Complex Affirmations
 - Will include their strengths, their intentions, their accomplishments or their efforts.
 - “You have tried hearing aids in the past. Thank continued commitment to improving



R=REFLECTIVE LISTENING



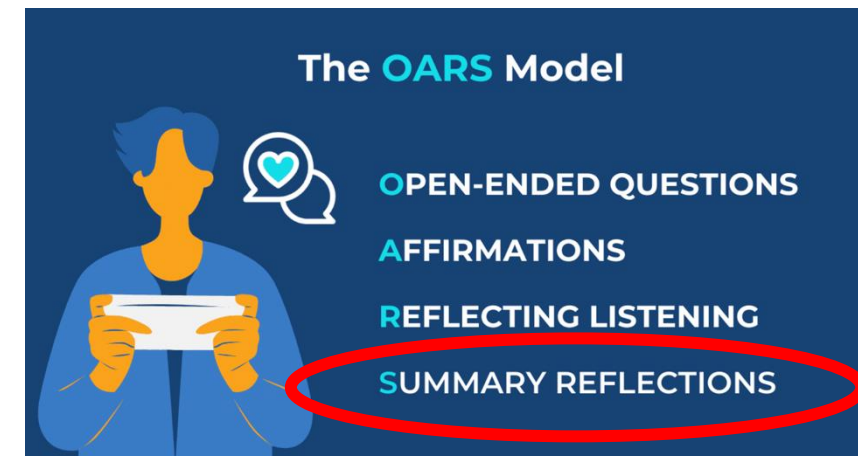
- What do you reflect?
 - **Reflect the resistant statement:**
 - “You don’t like the idea of getting hearing aids.” (Make a statement. Do not inflect your voice at the end b/c it puts patient on the defensive).
 - **Reflect the tone of what you are hearing:**
 - “You seem sad about the fact you need hearing aids.” or “You seem unhappy about needing hearing aids.”
 - **Reflect ambivalence:**
 - “On the one hand you think getting hearing aids can improve your quality of life, and on the other hand you are not sure you would use them so why waste the money.”
- Most important skill of MI - Sign of Attunement



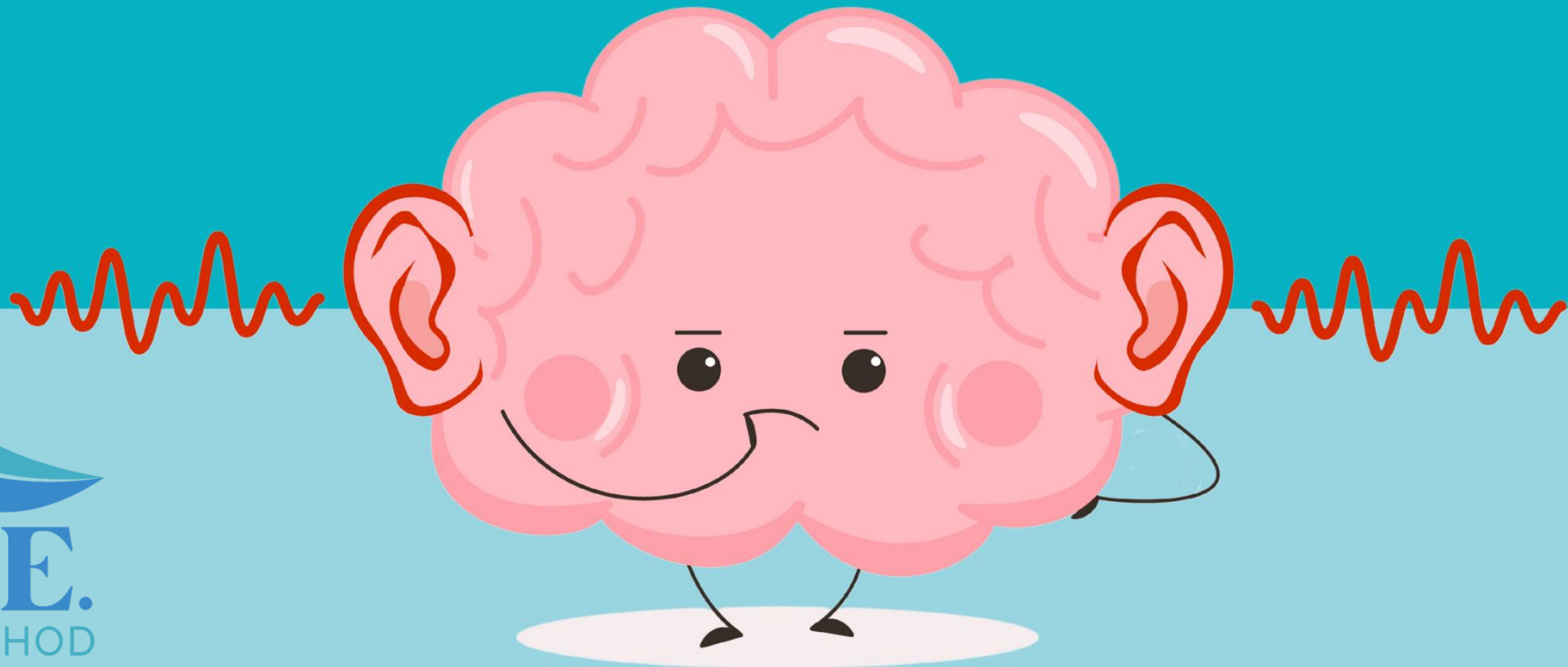
S=SUMMARY REFLECTIONS

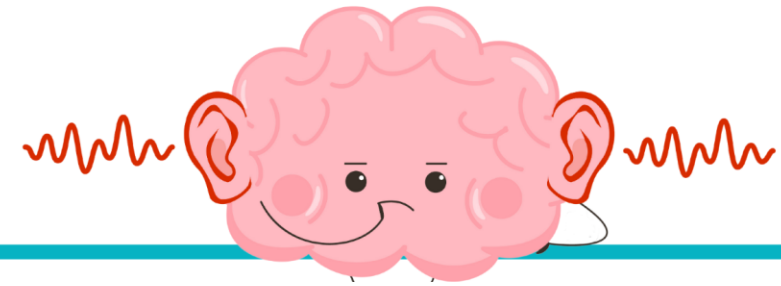


- A summary pulls together things that a person has said.
- It communicates to the patient, “What you tell me is so important that I remember it.”
- Summaries are an example of really good listening and attunement.
- Used at the end of the appt or used as a transition.
- Example:
 - “Before we move on, this is what I’ve got so far... tell me if I’ve missed anything.”



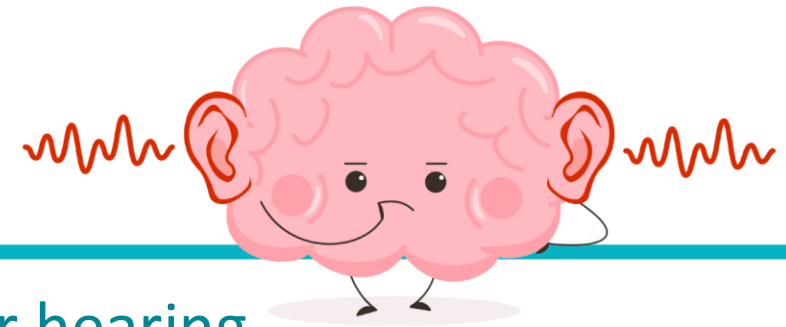
Implementation





H.O.P.E.	Our focus	MI task and skills
H — Hear the story	Experiences, concerns, and priorities	ENGAGING Open questions and reflections
O — Observe with curiosity	Communication access, meaning, and reasons for change	FOCUSING + EVOKING Clarify, reflect, and explore their “why”
P — Personalize the care	A shared goal and a workable plan	PLANNING WHEN READY Ask–Offer–Ask and plan together
E — Empower the person	Ownership, confidence, and informed choice	PLANNING + CONFIDENCE Affirm strengths and summarize the chosen next step

USE H.O.P.E. WITH MI AT THE HA EVALUATION



- 1) **H:** Tell me why you are interested in improving your hearing.
- 2) **O:** What would you say are the three best reasons for you to improve your hearing?
- 3) **O:** On a scale from 0-10, how important would you say it is for you to improve your hearing? *Then, when you hear the number, ask: And why are you at ____ and not zero?*
- 4) **P:** On a scale from 0-10, how much do you believe in your ability to use hearing instruments? *Then, when you hear the number, ask: And why are you at ____ and not a 10?*
- 5) **P & E:** How would you like to proceed?

***With ambivalent patients, use the box activity.

PLANNING

The client is willing to envision change
and how they go about making it

THE BOX & H.O.P.E.



1. ADVANTAGES OF STAYING THE SAME	2. DISADVANTAGES OF STAYING THE SAME
3. DISADVANTAGES OF ACTING ON HEARING LOSS	4. ADVANTAGES OF ACTING ON HEARING LOSS

H: Hear the story

- Explore their reasons for staying the same and for considering change.

O: Observe with curiosity

- Notice emotion or hesitation. Reflect tentatively and check your understanding.

P: Personalize the care

- Use their concerns and priorities to tailor hearing-care options and support.

E: Empower the person

- Summarize what matters to them and ask, “How would you like to proceed?”

TIPS/SUGGESTIONS

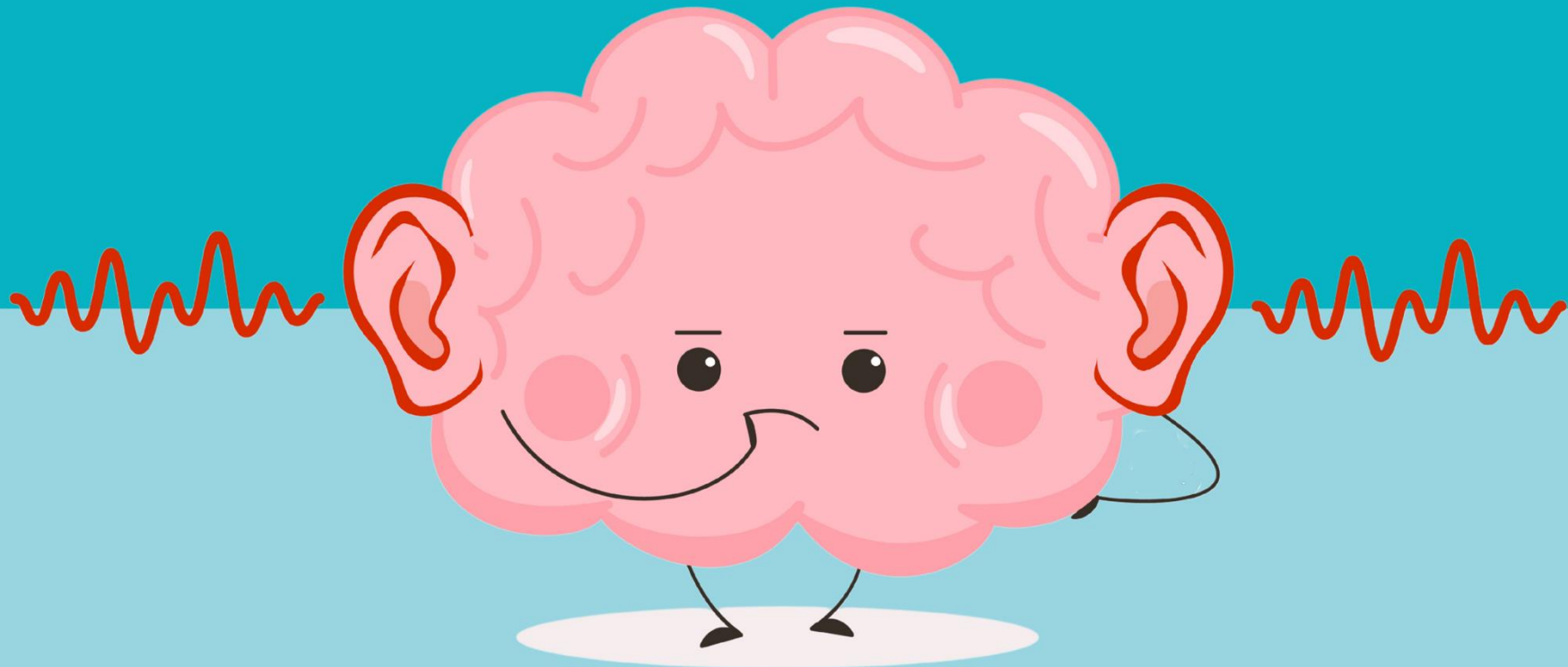


- ✓ Give the patient time and space to elaborate on their scores — the discussion is essential, not the scores themselves. Ask them follow-up questions. This will allow the patient to articulate their reasons, perhaps thinking deeply about this for the first time. Example questions:
 - "What would it take to increase your score from 4 to 8?"
 - "What can I do to help you go from 4 to 8?"

NOTE: You are always more likely to be convinced by listening to your own arguments and voice.

- ✓ Listen carefully to your patient's responses. Avoid telling them their concerns are not a big deal, they are real to them. They need validation!

WHAT'S UNDER THE SURFACE?



The mask or **behaviors** we see

Talking over us
Closed answers
Angry responses

Taking control
Going quiet
Quick agreement
Using humor

What **may** be below the surface

Emotions

Fear
Shame
Grief
Frustration or overwhelm

Needs and meanings

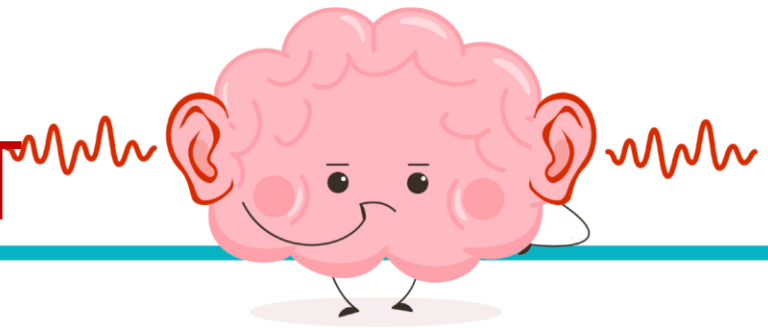
Safety and control
Dignity and independence
Being heard and respected
Trust

Past experiences

Mocked for
misunderstanding
Repeated humiliation
or rejection
Dismissed in health care
Abuse or loss of control

Possible influences. The patient's explanation guides care.

THE PATIENT WHO TAKES CONTROL OF APPOINTMENT



“Well, see, with me it’s different, because...” or “What I’m trying to tell you is...”

Possible protection

Taking the floor may protect the need to be heard and retain control.

How the past may matter

Repeated dismissal or decisions made without them may make control feel important.

H.O.P.E. in the conversation

- H** “It sounds like there’s a lot you want me to understand, and I want to hear it. I notice we’re talking at the same time. Could we take turns because what you have to say is important to me and I want to help?”
- O** “What is most important for me to hear first?”
- P** “How would you like to proceed?”
- E** “I want you to feel heard and make sure you’re heard because what you say is valuable and important.”

THE WITHDRAWN OR FROZEN PATIENT



“I don’t know...” coupled with long pauses, brief answers, or difficulty finding words.

Possible protection

Going quiet may create distance from overwhelm or feeling exposed.

How the past may matter

A humiliating or pressured encounter may make confusion feel unsafe to admit.

H.O.P.E. in the conversation

- H** “I’m noticing you seem quiet. Does this feel like a lot right now?”
- O** “What would help make this easier?”
- P** “We can slow down as we go. Would that be helpful?”
- E** Give them choice if they have confirmed they are overwhelmed or in shutdown: “Would you like to proceed with discussing?”

THE PATIENT WHO CAME FOR A SPOUSE



“I don’t need hearing aids. I’m here to make my wife happy.”

Possible protection

Minimizing need may protect independence or a valued sense of self.

How the past may matter

If needing help once meant weakness or lost control, devices may carry that meaning.

H.O.P.E. in the conversation

- H** “You came because this matters to your wife.”
- O** “What do you notice about your hearing?”
- P** “What, if anything, would you like to be easier?”
- E** “The decision about devices remains yours.”

THE ANGRY PATIENT



“I paid all this money, and I still can’t hear!”

Possible protection

Anger may communicate hurt or protect against another disappointment.

How the past may matter

Past dismissal or betrayal may make trusting a provider feel risky.

H.O.P.E. in the conversation

- H** “You’re frustrated with how this has gone.”
- O** “Tell me more about your experience.” – VALIDATE
- P** “What would a helpful outcome look like today?”
- E** “Let’s agree on a next step you want.”

THE PATIENT WHO USES HUMOR IN HAE



“I hear what I want to hear!”

Possible protection

Humor may protect dignity or keep painful feelings at a comfortable distance.

How the past may matter

Repeated teasing about hearing may make joking easier than expressing hurt.

H.O.P.E. in the conversation

- H** “You’re finding some humor in this.”
- O** “Are there moments when hearing is harder?”
- P** “What would you most like to hear more easily?”
- E** “You can tell me what is important to you and what concerns you. Your input matters as we talk through hearing aid options.”

IF YOU CAN ONLY REMEMBER 3 THINGS...

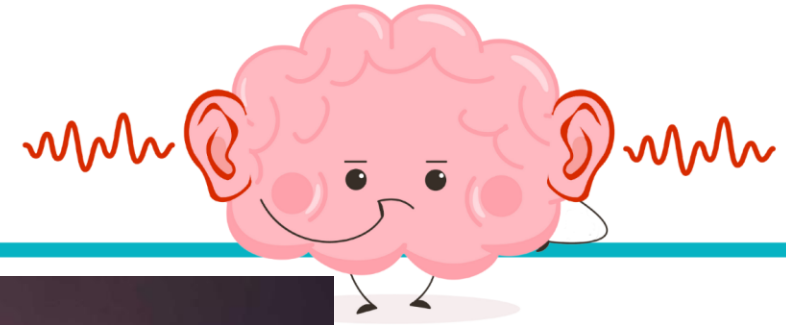


Stay curious.

Ask good questions.

Validate.

BE THE REASON YOUR PATIENT WANTS TO GROW



People need to feel seen,
heard, and valued to have
the desire to grow.

Marcia Reynolds

quote fancy

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QUESTIONS?

Thank you for listening!

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