Counseling Issues in Audiologic Rehabilitation

Kristina M. English
The University of Akron, OH

In Africa...some tribes have a remarkable way of greeting each other. When one person says hello, the response is “I see you.” Think how much better the world would be if we actually saw each other. (Clinton, 2007, p. 210)

Isn’t this an interesting concept? “Seeing” as described above means more than just the cognitive act of taking in visual information and associating a face with a name. There is also an acknowledgment that “You exist to me,” and an additional verification that “I am paying attention to you.” It also seems to imply respect. In the United States, this concept is used for the same intent but in different circumstances: As we come to understand a person’s point or idea, we often say “I see what you mean.”

When we counsel clients, parents, and family members, we are saying to them, “I see you.” While keeping a sharp eye on test results and available technology, we also attend to the humanity of the situation—the accompanying fear and frustration associated with hearing loss, and the deep desire to communicate with more ease while grappling with the discomfort of asking for help. And as we attend, we apply counseling strategies that are designed to help the client move forward, face one small fear at a time, and develop new skill sets and confidence.

Counseling issues in audiologic rehabilitation have not changed significantly over the years. New technology has made hearing aids smaller and more cosmetically appealing, even stylish. Advanced electronics are helping patients hear better in noise, and assistive devices continue to provide solutions to living with hearing loss. But human nature has not changed, so we want to understand as much about the psychology of hearing loss as possible. Some psychological aspects include the struggle to admit that a problem exists in the first place. Then, when a client does accept the problem, a tension develops between wanting to address the problem and resisting the solution (hearing aids).

Understanding these reactions is just one level of counseling. Like the word “seeing,” counseling has additional meanings, including actively helping clients move forward (counseling strategies) and teaching (informational counseling), as in counseling a client how to use her new hearing aids. We will look at each of these meanings as they apply to audiologic rehabilitation.

ABSTRACT: The effectiveness of audiologic rehabilitation has always been contingent on the audiologist’s counseling skills. Our understanding of counseling has deepened and broadened in the last decade, and is now a required course for virtually all audiology doctorate (AuD) programs. This article describes two aspects of this complex topic: understanding our clients as they adjust to change, and counseling strategies designed to help clients through the “help-seeking process.” We conclude with some suggestions on how students and clinicians can obtain feedback on their counseling skills, recognizing that “learning to counsel” is a lifelong endeavor.

KEY WORDS: counseling, stressors, self-concept, change, readiness, self-assessment

UNDERSTANDING CLIENT REACTIONS

Most individuals acquire some degree of hearing loss as part of the aging process, although this fact is small
consolation to clients. Clients often wait up to 7 years or more before they seek help for their hearing problems—and even then, their initial appointments are often made at the behest of family members, not because they are personally ready to seek help.

Our first task is to learn more about our client as a psychological and social being. Following are some ways in which we can start to understand our client.

Reactions to Stressors
When humans are faced with a situation that creates stress, we either approach the situation (by solving it, or finding help to solve it) or avoid it. Avoidance can take the form of cognitive avoidance (“I will think about this later”), emotional redirection (e.g., expressing anger about an unrelated situation), or cognitive distortion (making assumptions on false premises: “I can’t have a hearing problem because I am in perfect health”).

When clients start to experience hearing problems, psychological avoidance is a natural reaction. Clients can defer “thinking about it” because they still hear quite a bit, and no pain is involved. They can “explain it away” by blaming others for poor speaking habits. As the hearing loss increases, however, so does the stress, and those initial coping strategies become less effective. The first audiology appointment is the beginning step to approaching the hearing problem.

“Owning” the Hearing Loss
So far we have considered steps that clients work through before consulting with an audiologist (i.e., moving from avoidance to approach). However, anecdotal evidence suggests that perhaps only half of initial audiology appointments are made by clients because they perceive a hearing problem. More often, spouses and family members, frustrated with communication problems, insist that the client be tested. Clients understandably express resentment about the situation and will likely be suspicious of the audiologist’s motivation to help. Although the client has kept this appointment, the audiologist cannot genuinely help until the client “owns” the hearing problem; that is, not only accepts the reality of a permanent, untreatable health problem, but also decides to improve the situation. This “ownership” requires a client’s active engagement.

When we have a toothache, or our car has broken down, or the plumbing is clogged, we do not hesitate to get help: We pick up the telephone and call an expert immediately. Why is it different when the problem is a hearing loss? Once asked this question of a group of successful hearing aid users, and the audience took a few moments to think about it. Finally, a gentleman said, “With a hearing problem, you have to accept responsibility.” He went on to explain that in the first examples, once we make the phone call, our role is passive: The expert fixes the problem and we are not actively engaged in the process except to pay for the service at the end. In these examples, the problem is not perceived as personal. Rather, we are a consumer of goods or services, and we expect the expert to “own” (stand by) the solution.

When clients have a hearing loss, they may assume that this passive role will suffice, and expect that taking the initiative and paying for devices/services are all that they need to do. If this consumer orientation is not addressed, clients will be chronically dissatisfied. As mentioned earlier, clients have to own the hearing loss as a personal problem before they will commit to managing it.

Threat to Self-Concept
Only 20% of the population who would benefit from the use of hearing aids actually obtain and use them. When asked, people in the remaining 80% indicate cosmetic concerns as second only to the cost of hearing aids (Kochkin, 2005). What do cosmetic concerns mean to clients? Worrying about how one looks may seem superficial—after all, hearing aids are “just” plastics and electronics, in one sense. But an involuntary change in how one looks (body image) represents a very real threat to the core of our psychological existence, our self-concept.

Self-concept is defined as the perception of one’s traits, attitudes, abilities, and social natures; that is, the way we describe ourselves. Individuals initially are dependent on the messages given by caretakers to define themselves (I am loved/not loved; I am capable/not capable; I am/am not a worthy person). Over time, individuals decide for themselves how to define their self-concept by threading their cumulative life experiences into a developing tapestry. This tapestry represents hard work, with insights obtained through trials, mistakes, and successes.

Once we appreciate the importance of one’s self-concept, it is easy to see that the prospect of needing to change one’s self-concept is not going to be welcomed—in fact, it will be resisted if the change is perceived as a negative one. When we first inform clients that in fact they do have a hearing loss, their self-concept (“I am a person with normal hearing”) is under attack; when we add that in order to help the problem, we recommend using hearing aids (change one’s body image), the attack intensifies. The redefinition in one’s self concept from “I am a person with normal hearing” to “I am a person who needs hearing aids” can take some clients a great deal of time and support to accept.

Part of the resistance to this particular change comes from the phenomenon called the hearing aid effect. Our society has yet to accept hearing aids as a neutral technical device; instead, there tends to be a negative association with hearing aid use, with biased assumptions of reduced abilities, attractiveness, and intelligence. Many studies have examined this phenomenon, which was first identified by Blood, Blood, and Danhauer (1977). In their study, they showed participants a set of pictures of individuals, some wearing visible hearing aids and some not. When the individual’s instruments were visible in the pictures, the individuals were given lower scores in almost every category of intelligence, personality, attractiveness, and capability. These researchers concluded that the very presence of a hearing aid can stimulate negative reactions.
Clients are well aware of these reactions and struggle with the prospect of putting themselves in this kind of situation—to present to the public a persona that might not be respected or considered attractive. This is not an insurmountable barrier, but it is a real one that clinicians must respect.

Responses to Change

Change is occurring at an unprecedented rate, and yet we do not necessarily understand it. Human nature tends to prefer the status quo, even when change is in one’s best interests. It is stereotypical but true nonetheless that as we age, we are more uncomfortable with change, partly because we perceive that we have less time to adapt to it.

One day during a summer semester, I sat in a classroom waiting for the moment to begin class. Three students trickled in and sat down; one of them noticed that the other two happened to be wearing matching T-shirts. Because their hair was also the same color, they now looked remarkably alike. The first student dug her cell phone out of her backpack and took a photograph, and then one of the “twins” asked that the picture be sent to her mother with the note, “Hi mom, can u tell who is ur daughter?” Within 60 seconds, her mother sent a text response: “Hard 2 tell.”

The students laughed and changed topics, but I was rather dazzled. The technology they used did not even exist a few years ago, and now it is an everyday tool. I was reminded of two key points made in Friedman’s (2007) best-seller, The World Is Flat: (a) The rate of change is now breathtakingly fast, and (b) everyone and everything is becoming interconnected.

Friedman (2007) made the case that technological change speeds up interconnectedness, and vice versa, but I began to wonder if technological change might also impair interconnectedness, at least in audiologic care; that is, because new clinicians are so accustomed to rapid change, do they assume that their clients will be as comfortable with change as they are? More importantly, are they aware that change for clients with hearing impairment does not only involve technology but also psychology—that is, a change in self-concept and body image? And that psychological change might occur very slowly, if at all? Ultimately, could different experiences with change adversely affect the patient–practitioner relationship (interconnectedness)?

As we practice audiologic rehabilitation, we need to respond to many challenges, including keeping up with the almost daily changes in technology and also staying in step with the wildly variable change rates in humans and collections of humans (systems). Audiology and speech-language pathology as professions are systems, and every practice setting is a system. Rogers’ (2003) “adaptation/innovation curve” has been frequently used to describe the process of change within a system. Using the premise that some individuals are inevitably more open to change than others, he theorized that each system contains the following types of responders:

- Innovators (create change): 2%
- Early adopters (are eager to try change): 14%
- Early majority (accept change slightly sooner than average): 34%
- Late majorities (accept change only when most people have): 34%
- Laggards (accept change only when it becomes standard practice): 16%

Changing a system can take a very long time and frequently does not even succeed. Health care obviously is a system, and it too changes, but unevenly. McWhinney (2003) provided a detailed history of changes in patient care, starting with the traditional clinical model that was established in the 1880s when physicians began to record their bedside observations, use instrumentation such as the stethoscope, and so on. Simultaneously, the culture of the Industrial Revolution also shaped Western medical care: Patients were regarded as a collection of parts, much like machinery, and disease affected one or more parts. Treatment was designed to address the disease, but the patient’s experience was not factored in. The audiologic application of this model is an approach that, for instance, focuses on improving the perception of a 2000 Hz pure tone, but does not address the patient’s “problems of living” such as hearing conversation on the telephone.

Patients consistently expressed dissatisfaction with this impersonal clinical model. They complained that health care providers were not attending to their emotional responses, life events, relationships, or environmental challenges as they grappled with their illness or disability. A change to the system was introduced in 1964, when Balint proposed a “patient-centered” model of care. His approach highlighted the fact that a health care encounter includes two perspectives: the clinician interprets a health problem in terms of symptoms and signs, and the client interprets it in terms of experience. In this model, both perspectives matter, and the exchange of perceptions between client and clinician results in mutual understanding (developing common ground).

Engels (1977) then proposed a refinement of this model, recommending that health care take a “biopsychosocial” approach to help clinicians consider three domains of human existence: biological, psychological (reactions, coping strategies), and social. His model will resonate to those who are familiar with the World Health Organization’s (2002) International Classification of Function (WHO ICF). As comprehensive as this model is, some degree of dissatisfaction still existed. It was felt that this model might still continue to objectify clients as the sum of their parts, and the practitioner was still placed in the role of “fixer.” Shouldn’t there be more?

A third change was then proposed, which created an elegant nexus of change and interconnectedness. Tresolini (1994) led a team of authors working with the Pew Health Foundation to describe a model called relationship-centered care. By listening to client reports and focus groups, they concluded that “for patients, the relationship with their provider [italics added] frequently is the most therapeutic.
aspect of health care encounter” (p. 9). Relationship-centered care emphasizes the centrality of the patient–provider relationship, and addresses not only the biopsychosocial aspects of the patient experience, but also the role of the provider as partner in treatment, rather than expert and fixer.

Evidence describing the effectiveness of relationship-centered care has been compelling. When clients face decisions regarding diabetes management, smoking cessation, dialysis, or difficult medication regimens, they are more likely to adhere to recommendations when their relationships with their health care providers are supportive, caring, personal, and trusting (e.g., Golin, DiMatteo, & Gelberg, 1996; Squier, 1990; Stewart et al., 1999). These relationships help clients “grow in the face of changes within themselves and their environment” (p. 24).

This evidence is leading to changes in medical school training. Medical students are now required to pass practical “communication skill” exams and take courses to prepare them for these exams. A sample textbook (Cole, 2000) used in these types of courses describes a “three function approach” to client care. Take note of the first function:

- Function 1: Build the relationship.
- Function 2: Assess the patient’s problem.
- Function 3: Manage the patient’s problem.

So, all of these proposals to change over the years…and yet clients still complain of health care providers who do not listen, who focus on symptoms or changes to medication but not the person or the relationship. Proposals do not automatically change a system, and new clinicians trained in more recent models of care might find themselves in a system that adheres to the traditional clinical model (Duchan, 2004). Without some insight about the nature of change, new clinicians might be especially frustrated and disheartened.

Granted, the concept of systems change is esoteric, and new clinicians may have no real influence on a system until they have established some professional credibility. The concept of “client change,” on the other hand, is relevant from the first day of clinic, and we are all individually responsible for supporting that change process to the best of our ability.

Just as systems demonstrate a continuum of change, clients too experience a range of reactions to the prospect of change as they seek help for hearing problems. The “help-seeking process” (adapted from Hill & O’Brien, 1999) includes these stages:

- Stage 1: I don’t have a problem. A representative comment might be, “My hearing is fine! I’m only here to get my spouse off my back.”
- Stage 2: I have a problem but I don’t need help. “It’s true, I do miss some things, but it doesn’t cause any problems.”
- Stage 3: I have a problem and need help, but will not accept help. “I know I’m not getting every word, and my old hearing aids could stand to be replaced, but I have so many other health problems, I’m not up to any new challenges right now.”
- Stage 4: I have a problem and need help, will consider accepting help, but have some lingering concerns. “I’ve been noticing some problems in both ears, but if I consider hearing aids at all, I will only obtain one.”
- Stage 5: I have a problem, I need and want help, and I am ready to accept help. “I am really looking forward to hearing better, and am not worried about what other people think.”

When you interact with clients, are you able to determine where they fall on this continuum? If not, keep practicing: Write down what your clients say and try to understand what they are really saying about change. If you misunderstand, you may create problems instead of support; that is, you may move ahead assuming that your clients are ready for change, even when they have told you they are not. When clinicians misinterpret these cues, clients will invariably be frustrated and dissatisfied.

Understanding clients is the first step in counseling. The next step is to actively engage with clients to help them face their challenges. The next section describes two strategies designed to help clinicians engage the client in facing those challenges.

### COUNSELING STRATEGIES

Dozens of counseling strategies are described elsewhere (e.g., Clark & English, 2004; Flasher & Fogle, 2004; Luterman, 2001), and it is beyond the scope of this short article to provide in-depth guidance. However, two strategies will be described here as they relate to the help-seeking process described earlier.

#### The Readiness Scale

No one changes until they are ready to do so—in fact, as Hamlet observed, “The readiness is all” (Act v. Sc. 2). Let us consider a client who has reluctantly agreed with his spouse that their recent communication problems can be attributed in part to his changing hearing and is not too surprised to find out that his hearing test describes a moderate hearing loss. (Quiz question: What stage is this client in right now?)

The next step seems to be to discuss treatment (amplification). However, we are missing an important piece of information: We have no idea if the client is ready to consider amplification. Knowing that people move through stages in seeking help, only clients in Stage 5 are genuinely ready for amplification. What would be the outcome if the clinician moved ahead with a hearing aid fitting, when in fact the client was in any other stage, for example, was not ready, willing, interested, or motivated? We can be fairly certain that the client will report that the hearing aids are not helping him, and he will likely either return them after the trial period or use them inconsistently until they are placed permanently in a dresser drawer.

Why this predictable outcome? Because the client’s desires were not elicited, and he was not included in the
decision-making process. Adults (and children, too, actually) resent being told what to do, and no matter what age, we can count on a truism of human nature: If you push me, I will push back.

A simple step can be taken beforehand to prevent this from happening. The clinician can say, “Mr. Jones, now that we’ve confirmed your hearing problems, we can talk about how to make sounds louder for you with the use of hearing aids. But before we do, on a scale of 1 to 10, 1 meaning not at all and 10 being completely (as depicted in Figure 1), how would you rate yourself in terms of readiness? How ready are you to consider amplification?”

What will the client say? In spite of our best listening, we probably will not predict accurately. This is the one moment when clients are asked about their readiness to address the problem, and it can tell us exactly what we need to know.

Some possible responses:

- “Hearing aids? Forget it! I’m a 1 on that scale. I have no intention of using hearing aids.”
- “Hmm, that’s a tough question. I’m of two minds. I am curious but cautious at the same time. I’d say I’m a 6.”
- “I’d be an 11 or 12! I really need help, my job may be at risk, and I am past the point of pretending I don’t have a problem.”

Our subsequent responses follow the client’s lead. Those who are adamantly opposed to amplification have more on their mind and need time to talk about their concerns. They may also need time to get used to the idea, to visualize themselves as hearing aid users, and to talk to others about the decision. Those who are on the fence, as it were, can be encouraged to expand on their thoughts: Cautious because…? Curious enough to try? And those who express no reservations, who are genuinely ready, we can move forward.

Self-Assessments as Counseling Tools

Another counseling strategy is to use existing audiologic self-assessments as counseling tools. In addition to giving us a way to measure a self-perceived handicap, self-assessments also give clients a vehicle to describe to us their reactions and perceptions of living with impaired hearing, providing us a springboard into counseling conversations. For instance, the Self-Assessment of Communication (SAC; Schow & Nerbonne, 1982) is short (10 items) and includes not only questions about listening conditions, but also one’s reactions to them, as well as perceptions from significant others. Question #8 is intentionally nonspecific: “Is there anything about your hearing that upsets you?” If a client indicates agree or strongly agree, the clinician now has an opening: “Can you tell me more about this answer?” We will not know what is on our clients’ minds until we give them an opportunity to tell us. Self-assessments are a nonthreatening, neutral way to provide that opportunity.

Both of the counseling strategies described above are offered with the adult client in mind. The reader is referred to English (2002) for information and guidance when serving children and their families.

COUNSELING IS ALSO TEACHING

Clinicians do not typically think of themselves as teachers. However, every time we describe test results to a client, provide information about devices to a client’s family member, or inform parents about the nature of their child’s hearing loss, we are teaching; that is, we are conveying new and unfamiliar information to individuals who have assumed the role of learner. This process has come to be called informational counseling.

Informational counseling is vital to successful audiologic rehabilitation, and yet what do we actually know about it? Did we know, for instance, that when interacting with health care professionals, clients usually understand only half of the information provided? And when they go home and convey that information to loved ones, they accurately remember only half of that (Margolis, 2004)! In other words, in a typical information session, we are only 25% successful. This outcome would not be acceptable in any other aspect of audiologic rehabilitation practice.

We can evaluate our role as teacher by asking ourselves a few questions. Are we inclined to use the “information dump” approach, wherein we take the learner through a crash course of Audiology 101? We might as well continue that approach immediately because it is not effective. Rather than overwhelm the learner, we can strive to “dose” him or her with key points of information provided at strategic moments. The “dosing” strategy includes providing relevant written information for the client to read and reread when he or she is ready to absorb more details. Do we have those written materials (frequently asked questions sheets, brochures, Web sites) ready to distribute?

Also, do we provide information that we know would please our former supervisors, but that clients do not care about? A small study (English, 2001) found that when asked if they would like the “big picture” or the complete details of their initial evaluation, 3 out of 4 clients preferred getting the “big picture” (“You have a moderate hearing loss in both ears”) and then moving on to the recommendations. Luterman (2001) suggests starting each appointment with this query: “What questions do you have today?” A client’s questions reflect his or her readiness to learn the answers.

What about the mind set of the learner? We have long known that high-level learning occurs in the frontal cortex of the brain. Research has also shown that when a learner
is upset, afraid, angry, or shocked, his or her frontal cortex is not accessible (National Research Council, 2000). The limbic system, specifically the amygdala, responds to the stress of the moment with hormones that trigger intense emotions and effectively shuts off access to the frontal cortex. While in this state, the learner is simply not able to learn new information. Why would we explain about decibels and hair cells when the learner’s emotional state prevents him or her from understanding?

The main point is that informational counseling is not a monologue. The teacher must guard against losing the learner and check to see what the learner is ready to learn. Effective informational counseling is one of the art forms of audiologic rehabilitation, supported by the “science of learning”: neurological science and cognitive psychology.

EVALUATING AND IMPROVING COUNSELING SKILLS

The two basic components to learning any new skill are practice and feedback. Students have indicated that when they do practice counseling strategies, they get little or no feedback (English & Zoladkiewicz, 2005). If that is the case, the reader who is interested in obtaining constructive feedback is encouraged to use one or both of the following instruments with a supervisor.

The first instrument is called the “4 Habits Rubric” (Frankel & Stein, 1996; see Appendix). This rubric, which was originally developed for use within Kaiser Permanente, divides client interaction into four sections and provides descriptions of clinician behaviors ranging from poor to exemplary. New audiologists are encouraged to elicit a supervisor’s or peer’s initial evaluation of one interview or counseling skill (“habit”) and then discuss ways to improve that skill. Preceptors and externs using this instrument have rated it as a highly effective evaluation and feedback mechanism (English, 2008).

Another evaluation tool is called the Audiologic Counseling Evaluation (ACE; English, Naeve-Velguth, Rall, Uyehara-Isono, & Pittman, 2007). The ACE was designed to guide students and new audiologists through audiology’s most challenging counseling situation: informing parents about their baby’s hearing loss. It is designed to use with actors role-playing a parent while the student takes the counseling session through the following steps:

- **Getting started:** preparing for the parent consultation. The environment should allow private and comfortable communication, and the audiologist should indicate that a transition in the appointment is taking place.
- **Breaking the news:** imparting diagnostic information to parents with sensitivity and compassion. The audiologist should use lay terminology, attend to parent reactions, respond only to the questions posed, and resist tendencies to “fill up the talk time” with professional monologue.
- **Assessing parents’ understanding of reaction to the situation:** gauging parents’ perceptions and reactions.

The amount of information given will depend on what the parents already know.

- **Eliciting concerns:** gaining a clear idea of how parents perceive the implications of this information, and the concerns it might generate.
- **Giving a time frame for action:** describing upcoming events. The audiologist will want to convey the need for action while respecting the parents’ need to regain control of their family lives.
- **Suggesting specific actions while waiting for the follow-up appointment:** providing concrete suggestions about activities that parents can do between appointments, if they are so inclined.
- **General considerations:** the quality of the consultation as a whole. For example, did the audiologist appear supportive during the consultation? Use appropriate body language? Tailor the pace of the consultation to suit the parent?

The evaluator (supervisor, instructor, peer) rates 21 behaviors on a 1–5 scale and is given suggestions on how to advise the student to improve each behavior. The ACE is available online at http://gozips.uakron.edu/~ke3/ACE.pdf.

For more guidance on the important topic of parent and family counseling, please see English (2002) and Clark and English (2004).

CONCLUSION

This article began with the encouragement to truly “see” our clients. We considered a range of client reactions to hearing loss, including the threat to self-concept and the stress of change. We have reviewed the value of relationship-centered care as an approach that can help clients adjust to threats and change. And finally, two strategies were presented to help the reader begin the journey into nonprofessional counseling as audiologists and speech-language pathologists. As mentioned before, effective counseling is a lifelong learning project, and it starts with attending (seeing/listening). We end with a second quote on the topic:

The heart of good listening is authenticity…. Authenticity means that you are listening because you care, not just because you are supposed to. The issue, then, is this: Are you curious? Do you care?... If you think you already understand how someone else feels or what they are trying to say, it is a delusion…. There is always more to learn. (Stone, Patton, & Heen, 1999, p. 168–170)

REFERENCES


## APPENDIX (P. 1 OF 2). 4 HABITS CODING FORM

Student being evaluated: ____________________________________________

Rotation: ____________________________________________ Location: ____________________________________________

Instructions: Indicate rating (1 to 5) in each of the four categories AND provide constructive feedback below.

<table>
<thead>
<tr>
<th>Rating Categories</th>
<th>5 Exemplary</th>
<th>4 Acceptable</th>
<th>3</th>
<th>2</th>
<th>1 Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Investing in the beginning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Greets patient in a warm personal way (e.g., clinician asks patient how s/he likes to be addressed, uses patient’s name).</td>
<td>1. Greets patient, but without great warmth or personalization.</td>
<td>1. Greets patient in a cursory, impersonal, or non-existent way.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Makes non-medical comments, using these to put the patient at ease.</td>
<td>2. Makes cursory attempt at small talk (shows no great interest, keeps discussion brief before moving on).</td>
<td>2. Gets right down to business. Curt and abrupt.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Identifies problem(s) using primarily open-ended questions (asks questions in a way that encourages the patient’s story with minimum of interruptions or closed-ended questions).</td>
<td>3. Identifies problem(s) using open- and closed-ended questions (possibly begins with open-ended but quickly moves to closed-ended).</td>
<td>3. Identifies problem(s) using primarily closed-ended questions (staccato style).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Encourages patient discussion of concerns (ahah, go on, tell me more). Attempts to elicit the full range of the patient’s concerns early in the visit (clinician does other than simply pursue first stated complaint).</td>
<td>4. Neither cuts off the patient nor expresses interest (listens but does not encourage expansion).</td>
<td>4. Interrupts or cuts patient off. Immediately pursues the patient’s first concern without checking for other possible patient concerns.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eliciting the patient’s perspective</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Explores the patient’s understanding of the problem.</td>
<td>1. Shows brief or superficial interest in the patient’s understanding of the problem.</td>
<td>1. Shows no interest in understanding the patient’s perspective.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Asks (or responds with interest) about what the patient hopes to get out of the visit.</td>
<td>2. Shows interest in getting a brief sense of what the patient hopes to get out of the visit, but moves on quickly.</td>
<td>2. Makes no attempt to determine what the patient hopes to get out of the visit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Attempts to determine in detail/shows great interest in how the problem is affecting patient’s lifestyle (work, family, daily activities).</td>
<td>3. Attempts to show some interest in how the problem is affecting patient’s lifestyle.</td>
<td>3. Shows no interest in how the problem is affecting patient’s lifestyle.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX (P. 2 OF 2). 4 HABITS CODING FORM

<table>
<thead>
<tr>
<th>Rating Categories ↓</th>
<th>5 Exemplary</th>
<th>4 Acceptable</th>
<th>3 □</th>
<th>2 □</th>
<th>1 Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demonstrating empathy</strong></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>1. Clearly accepts/validates patient's feelings (e.g., I'd feel the same way... I can see how that would worry you...).</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>2. Makes clear attempt to explore patient's feelings by labeling them (e.g., So how does that make you feel? It seems to me that you are feeling quite anxious about...).</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>3. Displays nonverbal behaviors that express great interest, concern and connection (e.g., eye contact, tone of voice, and body orientation) throughout the visit.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td><strong>Investing in the end</strong></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>1. Frames diagnostic and other relevant information in ways that reflect patient's initial presentation of concerns.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>2. States information clearly with little or no jargon. Fully/clearly explains the rationale and significance of tests and treatments.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>3. Explores acceptability of treatment plan, expressing willingness to negotiate if necessary.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>4. Fully explores barriers to implementation of treatment plan.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>5. Effectively tests for patient comprehension.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>6. Makes concrete, specific plans for follow-up to the visit.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>1. Makes cursory attempt to frame diagnosis and information in terms of initial presentation of concerns.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>2. Uses some jargon. Briefly explains the rationale and significance of tests and treatments.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>3. Makes brief attempt to determine acceptability of treatment plan.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>4. Briefly explores barriers to implementation of treatment plan.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>5. Briefly or ineffectively tests for patient comprehension.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
<tr>
<td>6. Makes references to follow-up, but does not make specific plans.</td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
<td><img src="%E2%98%90" alt="☐" /></td>
</tr>
</tbody>
</table>

Copyright by The Permanente Medical Group, Inc. Used with permission.