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Research Article

"This Is a Partnership Between All of Us": Audiologists' Perceptions of Family Member Involvement in Hearing Rehabilitation

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Purpose: The purpose of the study was to explore the perceptions of audiologists about the role of family members in hearing rehabilitation for older adults with hearing impairment (HI), the influence of family member involvement on outcomes, and factors affecting family members' involvement.
Method: A qualitative descriptive research study was undertaken. Using a purposeful sampling strategy, 9 audiologists were recruited. Audiologists participated in individual semistructured interviews. Interview transcripts were analyzed using thematic analysis, and a process of member checking was used to enhance the trustworthiness of findings reported.
Results: The importance of promoting partnership emerged as the overarching theme. Audiologists valued promoting partnership with family members so that a shared understanding could be established, family members could be active participants with distinct roles in hearing rehabilitation, and the rehabilitation outcomes for the person with HI could be improved. Audiologists generally reported low attendance rates of family members to appointments and identified 5 major factors affecting family participation.
Conclusions: There is growing recognition among audiologists of the importance of promoting partnership with family members during the hearing rehabilitation process. More research is needed to develop and evaluate a family-centered model of hearing health care that considers the service-level barriers identified by audiologists in the present study.

It is well established that age-related hearing impairment (HI) is a chronic condition affecting not only the person with HI but also the person's family (e.g., Dalton et al., 2003; Preminger & Meeks, 2012; Scarinci, Worrall, & Hickson, 2008). For the person with HI, negative consequences are extensive, with social isolation, depression, and reduced quality of life often reported (e.g., Chia et al., 2007; Dalton et al., 2003; Kramer, Kapteyn, Kuik, & Deeg, 2002). Such negative consequences can also be mirrored in family members who may experience third-party disability as a result of their family member's health condition (World Health Organization [WHO], 2001). Scarinci, Worrall, and Hickson (2008, 2009) found that spouses of older people with HI experience negative effects (i.e., third-party disability) as a result of their partner's HI, including difficulties going out and socializing, relationship changes, communicative burden, and emotional reactions to the HI.

Given that family members can experience third-party hearing disability, it is not surprising that family members often prompt the person with HI to seek help for hearing difficulties (O Mahoney, Stephens, & Cadge, 1996; Stark & Hickson, 2004; van den Brink, Wit, Kempen, & van Heuvelen, 1996). Indeed, in a large retrospective study that involved 307 older adults with HI, positive family support was one of nine factors found to be associated with the decisions to seek help for HI and trial hearing aids (Meyer, Hickson, Lovelock, Lampert, & Khan, 2014). We also found that among older adults with HI who did not own hearing aids, positive family support was associated with a person's perceived confidence in his or her ability to manage the basic functions of a hearing aid (hearing aid self-efficacy; Meyer, Hickson, & Fletcher, 2014). Given that greater hearing aid self-efficacy has been identified as an additional factor influencing consultation for HI and hearing aid uptake (Meyer, Hickson, Lovelock, et al., 2014), positive family support might also promote help-seeking for HI indirectly by giving the person with HI confidence that he or she could manage hearing aids.

Family members have also been found to play an important role in the success of hearing rehabilitation for the person with HI. Hickson, Meyer, Lovelock, Lampert, and

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Khan (2014) established that older adults with HI were more likely to succeed with hearing aids if they reported that their family was more supportive of amplification. It might be that a family member who is more supportive of hearing aids is more inclined to be involved in his or her family member's hearing rehabilitation, resulting in better hearing aid outcomes. Preminger (2003) reported greater reductions in hearing handicap following participation in an aural rehabilitation program when older adults with hearing loss were accompanied by a significant other, most commonly a family member.

Hearing health care professionals should involve family in hearing rehabilitation for two reasons. First, people with HI will likely need the support of their families if they are to achieve successful hearing rehabilitation outcomes. Second, involving the family provides an opportunity for audiologists to address the needs of the family, not solely those of the person with HI. In other health conditions wherein third-party disability is recognized (e.g., speech pathology intervention for aphasia; management of dysphagia following head and neck cancer), family member involvement in rehabilitation has been encouraged for similar reasons (Brown, Worrall, Davidson, & Howe, 2011; Grawburg, Howe, Worrall, & Scarinci, 2013; Howe et al., 2012; Nund et al., 2014). The involvement of family during the provision of audiology services may be considered within a family-centered care approach to hearing rehabilitation.

Family-centered care is an approach most commonly used in pediatric healthcare services; however, it has recently been advocated in adult rehabilitation services (Arango, 2011; Bamm & Rosenbaum, 2008; Scarinci, Meyer, Ekberg, & Hickson, 2013). When using a family-centered care approach, clinicians address the needs of both the individual with the health condition and his or her family members. Central to family-centered care is the acceptance of the entire family as the patient and the involvement of family members in all aspects of clinical care (Epley, Summers, & Turnbull, 2010; Kuhlthau et al., 2011). Research in other areas of health care has demonstrated the many benefits of using a family-centered care approach to intervention, with documented improvements across a range of clinical aspects, including the individual's health condition, family behavior and functioning (including self-efficacy beliefs), access and efficacy of intervention services, and patient satisfaction (Dunst, Trivette, & Hamby, 2007; Kuhlthau et al., 2011; Wolff & Roter, 2008).

In a series of studies that evaluated the communication exchange between audiologists, older adults with HI, and family members during initial audiology consultations, family member attendance was low and family member engagement was limited (Ekberg, Meyer, Scarinci, Grenness, & Hickson, 2015; Grenness, Hickson, Laplante-Lévesque, Meyer, & Davidson, 2015a, 2015b). Video recordings of 63 hearing assessment appointments revealed that family members were only present in 27% of appointments (Grenness et al., 2015a, 2015b) and that their contribution to the clinical encounter represented only 13% of the total utterances spoken during these appointments (Ekberg et al., 2015). Conversation analysis showed that audiologists typically directed their questions to the person with HI, without openly encouraging input from any family members present. However, family members appeared to want to contribute, often answering questions that were directed to the person with HI or by asking questions of the audiologist (Ekberg et al., 2015). No research to date has explored how family members are involved during hearing aid fitting and follow-up appointments.

A number of factors could influence family member involvement during hearing rehabilitation. Preminger and Lind (2012) described clinical scenarios where the personality traits and attitudes of family members toward intervention strategies affected how audiologists involved family in their appointments. In addition, in a review of family-centered care, Bamm and Rosenbaum (2008) identified other factors that could affect the implementation of family-centered rehabilitation services, namely the overarching philosophies of organizations, the skill set and attitudes of health professionals, and the costs of services. In the context of WHO's (2001) *International Classification of Functioning, Disability, and Health* (ICF) framework, the attitudes of family members and health professionals, and likewise, service-level factors such as policy and cost, are considered environmental factors that could either be facilitators or barriers to family member involvement in hearing rehabilitation. These factors are yet to be studied in the context of hearing rehabilitation.

Despite there being a recognized need for family member involvement in hearing rehabilitation, it remains unclear how family members are currently involved throughout the hearing rehabilitation process, how family involvement may influence outcomes for the person with HI and his or her family, and what factors may facilitate or hinder family involvement. Therefore, the present study aimed to address these gaps in knowledge by exploring audiologists' perceptions of (a) family member involvement in the hearing rehabilitation of older adults with HI, (b) the influence of family member involvement on outcomes, and (c) factors affecting family members' involvement.

Methods

Participants

Participants were recruited using purposeful sampling to ensure variation in gender, workplace setting (e.g., public vs. private settings), and years of clinical experience. Recruitment strategies included advertisements at professional seminars and dissemination of information about the study through personal contacts. Recruitment continued until the research team felt that a range of perspectives regarding family involvement in hearing rehabilitation was discussed, and subsequently, that data saturation had been achieved. Nine audiologists, six men and three women, participated in this study. They ranged in age from 24 to 47 years old with a mean of 37 years, and they worked in a variety of settings, including privately owned practices, public sector

practices, and a university. The number of years working as an audiologist ranged between 1.5 and 17 years with a mean of 9 years. Participant demographic details are provided in Table 1.

Procedure

This study was conducted under the ethical oversight of The University of Queensland Behavioural and Social Sciences Ethics Research Committee. The interviews were conducted by the first author at a location convenient to the participants, with the majority being completed at each participant's workplace. The interview questions aimed to gain insight into how patients' family members are currently involved in hearing rehabilitation and to describe factors influencing their involvement (see the Appendix). For example, questions asked during the interviews included the following: "In your practice how are family members involved in hearing rehabilitation?" "What are the benefits/disadvantages of involving family members in hearing rehabilitation?" "In what situation is it easier/more difficult to involve family members in hearing rehabilitation?" The interviews ranged in duration from 33 to 77 min with a mean time of 49 min. The interviews were audio recorded and transcribed verbatim by a professional transcription service. All written transcripts were subsequently checked for content accuracy by the third author prior to data coding.

Data Analysis

Interview transcripts were analyzed using thematic analysis. Thematic analysis followed the six steps as outlined by Braun and Clarke (2006) and included an inductive approach where resultant themes were closely linked to the participants' data. The six steps included the following:

Table 1. Demographic information for participants (N = 9).

Variable	N (%)
Gender	
Male	3 (33)
Female	6 (67)
Age	
20–30	4 (44)
31–40	3 (33)
41–50	2 (22)
Years of experience	
0–5	3 (33)
6–10	1 (11)
10–15	3 (33)
15–20	2 (22)
Working status	
Full time	3 (33)
Part time	6 (67)
Workplace	
Private practice	6 (67)
Public sector	2 (22)
University	1 (11)

1. Gaining familiarity with data: Participant transcripts were read several times in their entirety to get an overall sense of participant views.
2. Generating initial codes: Content segments relevant to the purpose of the study were extracted from the transcripts, ascribed with an initial code or label, and collated into data groups according to content similarity. Outline tools in Microsoft Word™ were used to manage data codes and groups; themes were assigned Heading Level 1, categories as Heading Level 2, and supporting quotes as body text.
3. Searching for themes: Themes were found by examining the relationships among the data groups and sorting the data into higher and lower order categories.
4. Reviewing the data: Data in each of the initial overarching themes and categories were reviewed to ensure that the content included was relevant and accurately interpreted.
5. Defining and naming themes: Through an iterative process of reviewing the coded data and returning to the original interview transcripts, the final themes and subthemes found within the data were defined and named. Thematic saturation was considered to be obtained when no new categories, themes, or alternative explanations of the data were derived (Patton, 2015).
6. Producing the report: Supporting data for the overarching theme and subthemes were selected for the written report.

Coding was completed by experienced qualitative researchers with a background in communication disability (second and third authors). The third author did the initial coding after which the second author reviewed the coding; discrepancies in coding were subsequently discussed between the two authors until a consensus could be reached. The first author, who had conducted the interviews, verified that accurate conclusions of the data coding had been made. After this initial coding, all members of the research team were involved in subsequent data analysis at regular research meetings until a final set of themes was identified.

Rigor

As stated previously, peer debriefing and peer checking methods were used to enhance the rigor of the study. The data sample collected was deemed comprehensive because multiple exemplars, across a range of participant experiences, were obtained for each theme. A process of member checking was carried out to ensure that the identified themes accurately represented participants' perceptions of family member involvement in hearing rehabilitation. A six-page written document that outlined each of the themes was provided to participants. The document sought to determine participants' agreement with the study findings and gave participants the opportunity to provide further comments. Two participants no longer worked for the same organization where data were collected, and attempts to contact

them were unsuccessful. Of the remaining seven participants, four returned their summaries and indicated that they agreed that the themes were accurate representations. Of the four audiologists, three also provided additional written feedback that further supported the validity of the themes.

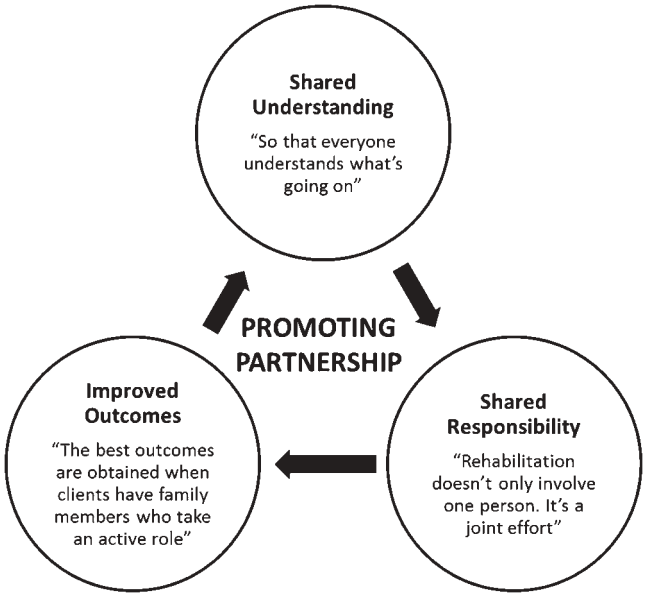
Results

The following results describe audiologists' perceptions of family member involvement in hearing rehabilitation and factors they felt influenced this.

Perceptions of Family Member Involvement in Hearing Rehabilitation

In general, audiologists reported low attendance rates of family members to appointments. Estimates of family member attendance ranged from 10% to 50%, with the majority of audiologists speculating that less than 30% of their appointments had a family member present. Despite perceiving attendance to be low, audiologists discussed numerous aspects of family member involvement in hearing rehabilitation. The overarching theme was promoting partnership with family members, which identified how, in general, audiologists valued the direct participation of family members in hearing rehabilitation. For example, comments such as "I would love family members to come along and be part of the solution" and "I think it is really important to get family members to buy in and give their opinion" and "I try to make it [rehabilitation] a shared thing" highlighted this central theme. Overall, three subthemes contributed to the overarching theme. Audiologists valued promoting a partnership with family members so that a shared understanding between all parties could be established; family members were active and continuing participants in hearing rehabilitation; and the rehabilitation outcomes for the person with HI were positive or improved. Figure 1 provides a visual depiction of the overarching theme "promoting partnership" and the interrelated subthemes of "shared understanding," "shared responsibility," and "improved outcomes." Each of these subthemes is described further below.

Figure 1. Model depicting family involvement in hearing rehabilitation from the perspective of audiologists.



Shared Understanding: "So That Everyone Understands What's Going On"

An important reason for family members to be involved in hearing rehabilitation was so that a shared understanding between the patients, their family members, and the audiologist could be established. Audiologists reported that usually their first contact with family members was during the initial assessment and/or case history stage of the audiology appointment. Hence, audiologists described taking case history as an opportune time to involve family members and obtain information about the nature of the patient's HI. Comments such as "You get a different insight into what is actually going on" and "Without that significant other there, the case history would be very different" were made by the audiologists. Audiologists detailed situations wherein the person with HI was either not fully aware or did not recognize all the difficulties he or she was experiencing, and thus input from family members was valued:

> I much prefer if there's a family member present. I think it makes people more accountable for issues that are actually happening in their daily life … I have found where I've had the husband for half the appointment and the wife's dropped in midway through, I'll learn a lot more once there's another family member present because they're more inclined to let you know of things that they've picked up on.

Audiologists also recognized that the person with HI and his or her spouse may not fully understand the impact of HI on each other. Hence, in some instances, audiologists valued having the opportunity to detail the impacts of hearing loss with families so that they were better able to "step into their partner's shoes." In a similar way, discussion about the effects of HI on family members was described by some audiologists as important. This was particularly emphasized by one audiologist who commented about working with spouses:

> So, it's usually not just the [patient] that's having trouble hearing the spouse. It's usually also the spouse that's being frustrated because they can't communicate with hearing their partner.

Shared Responsibility: "Rehab Doesn't Only Involve One Person. It's a Joint Effort"

Similar to the theme of shared understanding, audiologists reiterated that it was important to discuss the nature

of a family member's involvement and explicitly identify that member's shared responsibilities:

> We talk about what the responsibility of the spouse would be and what the responsibility of the [patient] would be, and they work out what their responsibilities are. I try and make it a shared thing so that everything's not all on the hearing impaired person, or on the spouse.

In general, audiologists identified that family members had four possible roles in audiological rehabilitation: (a) offering input into decisions surrounding intervention options and goal setting, (b) processing the information provided during the consultation, (c) supporting the client in achieving hearing rehabilitation goals, and (d) providing emotional support. The first role, family participation in decision making, was seen as important to enable families to share in the rehabilitation process and support the person with HI:

> You know what, take that information, take all of this information, take it back home, talk it through with your family, and then either give me a call, or I'll give you a call in a couple of days, and we can chat…So it's much more about something about allowing those decisions to perpulate [sic] back into the family, so the whole group can make the decision, or be involved in the decision, or support the decision, rather than this person just coming home and going "Well I got hearing aids."

Audiologists often described how they incorporated the use of published materials such as the Client Oriented Scale of Improvement (COSI; Dillon, James, & Ginis, 1997) to obtain family input during consultations. For instance, audiologists made comments such as "I tend to be quite blatant, I say 'What is it that you want to achieve,' and I will address that to both people, and then follow that conversation through." Furthermore, in using the COSI, some audiologists identified how they set "family" or "group goals":

> I went through a big long spiel, but I said that rehab doesn't only involve one person. It's a joint effort. It involves everyone who communicates to the person with a hearing aid and I just said to get the best outcomes, the best possible outcomes, arguably it's best if family members are also involved in that. I said how it might be best if we set, I called them "group goals."

and

> Often the [patient] will say "I really don't have that much of a problem with this or that," and then you look at the husband or wife or child who's sitting slightly to the side and behind, and they're shaking their head or making kind of gestures to suggest otherwise. So that's quite useful information for us, to then says "Well maybe that's still a worthwhile goal and let's get everyone contributing to the COSI goals."

Second, audiologists described the benefits of having a family member present to assist with the understanding and recall of information being provided during audiology appointments. One audiologist summarized this by saying "four ears are better than two." Specific information that was described as important for family members to process included feedback about hearing test results, recommendations for intervention options or hearing aid selection, and outcomes that might be expected:

> The family member to be successful needs to be supportive; needs to understand the expectations and limitations and advantages of rehabilitation options, so hearing aids, assistive listening devices, communication strategies, all those sorts of things, so that they need to be aware of that as well.

Third, audiologists discussed the specific role family members had in supporting the person with hearing loss in achieving his or her goals:

> They [family members] are solution focused predominantly, so you have them as part of the solution. Make them part of the exercises. Work out where their difficulties are and then see how you can work around that, what you can do, so that they feel part of it. If that's a real issue and you can find a way of addressing it, then hopefully you get success and you get the outcome.

If communication strategies were being recommended, audiologists reported educating family members about such strategies (e.g., ensuring they are in same room, facing the person with HI when talking) and encouraging family members to use them: "Well usually they've [client and family member] got into some pretty bad communication habits and they're both sided. Communication is two-way. So it's just trying to educate both parties." In the case of hearing aids, family member attendance was also valued so that family members could learn how to correctly insert the hearing aid, change the batteries, and clean the hearing aid: "If they [client] forget how to do something [with their hearing aid] … having someone else there that can help them with the process is really important."

Last, audiologists discussed how living with HI can be difficult and that the adjustment to wearing hearing aids can be an emotional time for some individuals. Hence, family participation was described as important for a source of overall support:

> I just think if you have a disability and you feel as though someone is supporting you, it is so much easier to deal with than if you're feeling as though you're on your own.

and

> Appointmentswise, in an ideal world, I'd love them [families] to come to the three main appointments; the assessment, the fitting, the review so that the family member with a hearing aid knows that they're

being supported through this whole—especially if they're new to hearing aids—through this whole new kind of a big life change for them. So ideally I'd like them to be at all three appointments.

Improved Outcomes: "The Best Outcomes Are Obtained When Clients Have Family Members Who Take an Active Role"

Responses during the interviews identified the value and benefit of family member participation in hearing rehabilitation. At the start of the rehabilitation program, audiologists valued family input about the nature of hearing difficulties as it facilitated the development of a more specific and tailored program:

> So, that's how they [family members] can help you, is you're more aware of the bigger picture, so you can address the program accordingly.

Audiologists described how they felt better outcomes were achieved when they had "supportive" family members who actively engaged in the rehabilitation process:

> Getting the family members involved and active in the rehabilitation program, usually we find that we get a lot greater success with [family members] on board. So if they feel supported by their family, if their family is helping them out with their rehabilitation program, we often find that there's a much greater success in terms of [patient] outcomes.

Family participation in rehabilitation was also seen as a means to facilitate good hearing aid management and subsequently improve outcomes such as patient satisfaction. For example:

> I find that family members who are more involved, the [patient] will be a lot happier with the hearing aids. They find that they're managing them a lot better because family members will obviously practice with them at home. I find that if they are having troubles with the devices, they're [family member] a lot more forthcoming with that information so that the hearing aids can be improved. I think those are the main things that I've noticed.

The importance of family participation on hearing aid outcomes was particularly exemplified when one audiologist described the impact of no family participation:

> If their spouse isn't on board with hearing aids, they're not going to do well. If the spouse goes "You don't need hearing aids, they're horrible, they're useless, they don't do anything," I've got this person for three hours in their rehab program, their spouse has them for 24 hours a day. If the partner isn't on board, or if the family isn't on board, things don't work.

One audiologist also reflected on how you could achieve good outcomes when working with family members who may be perceived as "less supportive" or "difficult" to work with:

> There are times when the spouse is a real facilitator in the process and there's times when it's difficult to work with the spouse and the partner, but that's just part of the job. If you hit something difficult, it's good that you've identified that that's a bit of an issue and working through that will mean a better outcome for the client.

Factors Affecting Family Member Involvement

The third aim of the study was to explore factors affecting the involvement of family members in the rehabilitation process. Five major factors were perceived to affect family member involvement in hearing rehabilitation: (a) approaches to family involvement, (b) time barriers, (c) misconceptions about hearing aids, (d) mismatched needs and priorities, and (e) family dynamics. Each of these is described in detail below.

Approaches to Family Involvement

Analysis of the interview transcripts revealed the importance of the audiologist and the role of the clinic in supporting family participation in hearing rehabilitation. For example, some audiologists highlighted the value they placed on family participation by saying:

> So we're making the assumption right from the word go that it is a family that you're treating, or a community that you're treating.

and

> There's a quote. I can't remember the exact wording, but it's something like … when someone in the family has a hearing loss, the whole family has a hearing problem.

Throughout the interviews, audiologists reflected on strategies they or their clinic used to encourage family attendance at appointments (e.g., encouraging attendance of family when booking an appointment; using verbal and written reminders):

> I mean this hearing center's really good—at every stage when they're confirming the appointment they'll say "Now have you got somebody to bring with you?"

Furthermore, audiologists described how they reiterated the importance of family attendance when family members did not initially attend consultations:

> Well if they're not at the assessment appointment, generally what I do is I tell the [patient]—"The next appointment is quite important and you may feel more comfortable if there's a family member there with you"—and I usually say that right at the end of the appointment.

Although all audiologists felt family member involvement was important, comments made during the interviews highlighted variability with how audiologists approached the inclusion of family members in their appointments. For

example, sometimes audiologists had opposite views about their direct role with family and who they considered their "client" to be. Some audiologists felt that family members were patients in their own right:

> **Researcher:** Who do you see as your client?
> **Participant:** The [patient] and their family members. I certainly think of the family as being an important part of that appointment, so they're [patients] as well."

Others indicated they did not necessarily see a family member as a "client" and, at times, this appeared to affect the emphasis placed on family member participation:

> **Researcher:** Describe what you see as your role with the family members?
> **Participant:** Probably nothing too direct, just I'm their partner's audiologist and I'm the person that gets the hearing loss and gives them the tips and keeps them up to date with information, with newsletters. Yeah, a facilitator of how they progress with their rehab program.
> **Researcher:** If you've got the person with hearing loss and the family members then, who do you see as the client?
> **Participant:** The person with the hearing loss, definitely.

Time Barriers

Audiologists reported a number of time barriers that influenced family participation in hearing rehabilitation. The first included the limited opportunity for audiologists to involve family members in appointments due to scheduling difficulties. For example, audiologists spoke about difficulty scheduling appointments at a time that is suitable for both the person with HI and their family members. A few of the audiologists explained how this was particularly true for family members of working age. For example, one audiologist commented:

> I have many [patients] that would love to bring their significant others but can't because of work [or] life demands and other [patients] that are so busy that they just want very quick appointments because of work [or] life demands.

To help with scheduling difficulties, some audiologists acknowledged the need to extend their clinic opening hours to include evenings and weekends: "I know some centers I've been in, we've opened on a Saturday for that very reason, so family can come."

The second time barrier reported to influence family member involvement included the time pressure placed on audiologists during an appointment. Audiologists described how the number of tasks required to be completed during an appointment left little time to provide detailed information to patients and to work directly with family members. Comments such as "I don't think we have the time to go through things in a lot of detail" and "The largest pressure on the auds [audiologists] and this is kind of what you're always trying to alleviate, is time. They're just up against the clock all day" were made. The importance of needing more time during appointments to work adequately with family members was explicitly expressed: "It [family member involvement] makes the appointment a lot longer. It's a harder appointment and it's harder to keep it on time. There's just more questions to answer and there's two opinions that you might need to address." Providing longer appointment times, however, was not always seen as feasible. Audiologists primarily identified barriers such as the extra cost to the patient, limited staffing, and high caseload demands preventing the implementation of longer appointments.

Misconceptions About Hearing Aids

Another key issue influencing family member participation included factors related to an individual's knowledge about HI and the rehabilitation process. In general, audiologists perceived that before attending their clinics, patients and family members often had a limited understanding of the nature of hearing rehabilitation as well as the range of rehabilitation choices and/or strategies available. Although audiologists recognized their role in providing this information, they felt this was a barrier because it created a broader perception that "the significant other doesn't feel the need to come along." Audiologists provided analogies such as:

> People think that the process of rehabilitation—they wouldn't even think of it as rehabilitation, they would think of it as getting a hearing aid is akin—most people think of it as akin to getting glasses, so they're not going to necessarily figure that they would be needed or helpful.

Audiologists also reported that both patients and family members often consider the adoption of a hearing aid to be a quick fix and that many do not fully appreciate the length of time required to adjust to wearing the hearing aid and that communication strategies may also be needed:

> **Researcher:** So what knowledge do you think that people with hearing impairment have about hearing loss and hearing aids, and communication?
> **Participant:** Very little. Even the ones who've had hearing aids for years, basic things like put your head up against a wall when you're at a restaurant. They say "Oh really?" So communication strategies aren't well known. Hearing aids are still seen as "Why can't I hear perfectly?" So that education that it's nerve damage, we can't regrow nerves, that hasn't gotten out and the fact that people with normal hearing have trouble hearing sometimes.

Mismatched Needs and Priorities

During the interviews, audiologists identified that often there can be a mismatch between the perceptions and/or needs of the person with HI and his or her family members. Audiologists described how, in some instances, there may

be discrepancies about the perceived level of hearing and associated difficulties. For example, one audiologist said: "There are some people that will swear blind that there's nothing wrong and then the significant other will list off countless issues that are going on." In other instances, audiologists described a mismatch in terms of treatment options. For example, they detailed situations where a family member may not be fully supportive of the person with HI adopting hearing aids, or conversely, that the family member is the driver of the appointment and the person with HI is not yet ready to adopt hearing aids:

> It can be a case of occasionally too, where a [patient] is not quite ready for hearing aids and for them [patient] they don't feel like they're necessarily enough. But the family members might feel that they definitely need this. Sometimes it can be a case of yes, the [patient] does need it but sometimes maybe the [patient] doesn't need that option, they might need a different option and really trying to get that across to the family that maybe they're not quite ready for that option yet and they need to start with this option and then we'll look and see how that goes and move onto something else. Again, that's just about educating the family as much as you possibly can. And that can sometimes be challenging as well.

Discrepancies between the person with HI and his or her family member in terms of goals for rehabilitation and expectations of hearing aids were also frequently discussed. Audiologists described circumstances where either the person with HI or the family member had "unrealistic expectations":

> Sometimes I think the partners, especially if they weren't there for the initial appointment, sometimes have unrealistic expectations about the outcomes themselves. So sometimes I have had people that have only attended for the follow up appointment and have come in and said "But I'm still having to call out to him twice when I'm at the other end of the house," and you say to them "Well is that realistic to expect him to be able to follow every word you're saying when perhaps you're not playing your role in this communication partnership?"

When faced with a mismatch between a patient and his or her family member, some audiologists described how it was particularly important to provide education and explicitly involve family members in the goal setting process so that the mismatch in perceptions and expected outcomes could be openly addressed.

Family Dynamics

Audiologists acknowledged that hearing rehabilitation needs to be individualized on the basis of the family dynamic in front of them. One audiologist commented that "providing individualized approaches to suit both individuals and their families is absolutely crucial in implementing an effective rehabilitation program."

As already highlighted, audiologists perceive there to be many benefits of involving family in hearing rehabilitation. It is important, however, that audiologists identified some scenarios where they felt that family involvement was challenging or less appropriate, depending on the family dynamics. This was evident in the following quote:

> I think it is important to remember that a family member needs to be a positive force in a client's rehabilitation. If they are not supportive (even with multiple encouragements) it is important to note that they can sometimes be a negative influence on the client.

Another audiologist reiterated that, despite their best efforts to actively seek family support, some significant others simply do not wish to be involved:

> I could also think of some where the spouse is quite negative towards the whole hearing rehabilitation, and the [patients] will openly discuss that, and even though you try and use strategies to get the spouse in, so that you can try and talk about the problems that the [patient] might be experiencing, to help them understand and help the whole communication process happening better, the [patient] relays to me that the spouse just won't have a bar of it, that they just won't come.

A limited understanding of family members' roles in hearing rehabilitation was identified by some audiologists as a factor influencing family involvement:

> The disinterested ones is [sic] a little bit harder. Probably it's more an education thing for them, so we talk about how important it is in terms of the client's needs …[text removed due to length] and explain to them how important their role is.

References were also made to factors in family relationships that sometimes impede family participation. For example, one audiologist described how "tension" within a relationship may prevent a spouse from becoming involved. Likewise, another audiologist spoke about the importance of ensuring that there is not "a huge amount of frustration" in a relationship before immediately involving family members. In other instances, more general comments were made such as "I think it [family member involvement] really depends on the dynamics of the relationship between the [patient] and the family member or significant other."

A small subset of audiologists further identified that the cultural background of a family may also be another factor that influences family participation:

> …there are some very strong cultural difficulties around, particularly we have quite a strong Polish and Maltese populations, and something about the Maltese men is they just do not want their wives to be there, in a lot of cases. It actually goes both ways. A lot of the women won't want to be in their husband's appointments.

Discussion

This study explored the perceptions of audiologists about the role of family members in hearing rehabilitation, the influence of family member involvement on outcomes, and factors affecting family member involvement. Data from nine in-depth qualitative interviews revealed one major theme—the importance of audiologists promoting partnership with family members—and three interrelated subthemes: shared understanding, shared responsibility, and improved outcomes. Audiologists valued promoting a partnership with family members so that a shared understanding between all parties could be established, family members were active and continuing participants in hearing rehabilitation, and the rehabilitation outcomes for the person with HI were positive and/or improved. Further analysis of the interview data also exposed several factors that may affect family participation: (a) approaches to family involvement, (b) time barriers, (c) misconceptions about hearing aids, (d) mismatched needs and priorities, and (e) family dynamics.

Audiologists identified the history-taking phase of initial audiology consultations as an important time to involve family to promote a shared understanding of how HI is affecting the patient and his or her family. It has been well established in the literature that HI results in a communication disability that negatively affects the person with HI and the relationship with his or her spouse (Scarinci et al., 2008, 2009), and thus it is likely that important case history information would be overlooked if the family members' perception of the communication disability was not sought. Despite audiologists in this study reporting that they valued family input during the history taking phase, a recent study in which initial hearing assessment appointments were directly observed revealed that family members contributed on average only 28 utterances (approximately 10% of total utterances) during the history-taking phase (Grenness et al., 2015a). Thus, there appears to be a disparity between what audiologists strive for in clinical practice and what they are able to implement.

Given that HI affects both the person with HI and his or her family, audiologists commented that everyone needs to share responsibility for the communication difficulties that arise from HI. Hence, audiologists identified a number of important roles for family members in the hearing rehabilitation process. For example, audiologists recognized the importance of family member input into decision-making and goal setting, and some commented that they set family goals. Such practice is in line with principles of family-centered care (Epley et al., 2010) promoted in the wider healthcare context, as well as a growing body of literature advocating for joint goal setting in hearing health care (Laplante-Lévesque, Hickson, & Worrall, 2010; Manchaiah, Stephens, Zhao, & Kramer, 2012; Preminger & Lind, 2012).

Audiologists also identified a number of support roles for family members during the hearing rehabilitation process. For example, audiologists described how family members could assist with information recall, the implementation of communication strategies, and hearing aid management. Family members were also recognized as being able to provide individuals with HI the emotional support that they require as they adjust to living with HI. These findings are in line with other research about the important roles of family members in primary health care (Ellingson, 2002; Schilling et al., 2002; Wolff & Roter, 2008).

It is positive that the audiologists involved in this study recognized that family member involvement in hearing rehabilitation often resulted in improved outcomes for the person with HI. Audiologists described how family member involvement helped formulate individualized management plans, a key component of family-centered care (Epley et al., 2010). In addition, audiologists acknowledged how family member involvement benefited hearing aid management and hearing aid outcomes, consistent with what has been suggested in the literature (Hickson et al., 2014; Manchaiah et al., 2012). When the audiologists described the benefits of family member involvement in hearing rehabilitation, however, they tended to focus on the acceptance and use of amplification, not recognizing potential benefits in psychosocial functioning that have been described elsewhere (Dunst et al., 2007; Kuhlthau et al., 2011). In addition, the audiologists did not recognize how family members, too, could benefit from being involved in the hearing rehabilitation process. This might be because most of the audiologists viewed their patient as solely the person with HI and did not necessarily recognize that when one family member experiences a change, whether positive or negative, other family members are also affected (Goldenberg & Goldenberg, 2013). Given that family-centered care considers the entire family as the patient (Epley et al., 2010) and that family-systems theory acknowledges the importance of considering an individual's behavior in the context of the family network (Goldenberg & Goldenberg, 2013), it appears that audiologists currently do not embrace true family-centered hearing health care and thus may not be aware of the full extent of benefits one might observe from family member involvement in hearing rehabilitation. Given the empirical evidence supporting family-systems theory in other areas of chronic healthcare management (Martire, Schulz, Helgeson, Small, & Saghafi, 2010), and that inclusion of family members in treatments has the potential to improve family communication (e.g., Kalischuk, Nowatzki, Cardwell, Klein, & Solowoniuk, 2006), family-centered care seems particularly relevant to audiological practice.

Family member attendance at appointments appeared to vary; however, it was often reported to be less than 30%. This statistic is comparable to that reported by Grenness et al. (2015a, 2015b), who found family members attended 27% of initial hearing consultations. In other areas of health care, family member attendance has been found to be between 20% and 86% depending on the type of appointment; attendance was lower during routine primary care visits and greater during oncology appointments (Ishikawa, Roter, Yamazaki, & Takayama, 2005; Jansen et al., 2010; Wolff & Roter, 2012). One would expect family member attendance

at audiology appointments to be greater than that during routine primary care visits given that HI results in third-party hearing disability (Scarinci et al., 2008, 2009). In a parallel interview study we conducted with adults with hearing loss and family members, however, it became apparent that participants were sometimes unaware of the full impact of hearing loss on their communication and perceived technology as the only solution to hearing-related communication difficulties (Scarinci, Meyer, & Hickson, 2015). Thus, limited knowledge and understanding of hearing loss and of the role of family members in hearing rehabilitation may account, in part, for low family member attendance at audiology appointments.

Indeed, audiologists involved in the present study primarily attributed low family member involvement in hearing health care to the attitudinal environment of the person with HI, as well as other environmental-level barriers within WHO's (2001) ICF framework. Consistent with reports from adults with hearing loss and family members (Scarinci et al., 2015), audiologists commented on how family members often had limited knowledge of HI and the hearing rehabilitation process and thus did not recognize how and why they should be involved. In addition, audiologists described how family members sometimes had a different perception of the hearing disability, compared to the person with HI, and likewise a different attitude toward amplification. Mismatched needs and priorities can generate tension within audiology appointments (Ekberg, Meyer, Scarinci, Grenness, & Hickson, 2014). Thus, audiologists who do not feel comfortable addressing such conflict may be reluctant to involve family members if they foresee that their involvement would result in tension.

Service-level factors at the environmental level of the ICF framework also affected family member involvement in hearing rehabilitation. The most commonly reported service level barrier was time. Audiologists commented on how it was difficult to schedule appointments with family members who needed to arrange time off work and to involve family and still complete all the tasks they needed to within an allotted time frame. Some audiologists recognized that a change in service delivery is needed. For example, one audiologist reported extending opening hours to better accommodate family members. Another audiologist commented, however, that extended opening hours or extended appointments would come at a cost, and she was not certain who would be responsible for covering that cost. However, there is much uncertainty within the literature as to whether family involvement does increase the duration of appointments (Ishikawa et al., 2005; Jansen et al., 2010; Street & Gordon, 2008). Further research is necessary in hearing health care to better understand the service level effects of including family members.

It is important that service-level facilitators were also identified by the audiologists. In particular, some clinics had strategies in place to promote family member attendance at appointments. For example, administrative staff and/or audiologists would recommend that the person with HI bring along a family member to the appointment, either at the time of booking or during or following an appointment (in preparation for the next appointment).

Clinical Implications and Future Directions

Involving family members in hearing health care is an important first step in moving toward a family-centered model of care. However, mere attendance of family members at appointments does not constitute true family-centered care; simply being present during an appointment does not equate to active participation in the consultation. Audiologists can promote true family-centered partnerships by ensuring that all stakeholders understand the impacts of the HI on each person involved (i.e., shared understanding) and subsequently develop mutual goals for reducing the impacts (i.e., shared responsibility). This suggests the need for a change in mindset, from the patient being defined as only the person with HI to the patient being both the person with HI and his or her family. However, audiologists need to take an individualized approach when involving family members; audiologists identified that the family dynamic can influence how appropriate it might be to involve families in hearing rehabilitation.

Before family-centered care can be fully embraced in audiology, however, a number of barriers need to be addressed. With respect to a person's attitudinal environment, it seems important that audiologists educate the person with HI and his or her family about the various roles family members can have in hearing rehabilitation and how family involvement can improve outcomes. In a similar way, there appears to be a need to train audiologists in how to manage potential conflict between a person with HI and his or her family when there is a disagreement about the presenting hearing disability and/or the need for amplification. Unresolved conflict could conceivably affect treatment outcomes, in which case family member involvement would be counterproductive.

Time was the most commonly reported service-level barrier to family involvement in hearing rehabilitation. In order to involve family of working age, typically adult children, we need to explore novel methods of service delivery. There is growing support for the application of eHealth in hearing rehabilitation (Laplante-Lévesque, Pichora-Fuller, & Gagné, 2006; Thoren et al., 2011), which may provide opportunities to involve family members in appointments without them needing to leave the workplace. In order for audiologists to effectively achieve all they need to in an appointment, as well as promote family member involvement, it would also be worth reevaluating how audiology appointments are structured. For example, there may be opportunities to collect medical history information prior to the appointment, and then focus on how HI is affecting the person with HI and his or her family member during the history-taking phase.

The findings from this study reflect the perspectives of nine audiologists working in adult hearing rehabilitation in Australia. Although we feel that the participant data is rich, capturing a diverse range of experiences of involving

family members in hearing health care, we recognize that the present study was explorative in nature; more research is needed to better understand family involvement in hearing rehabilitation. Nevertheless, we feel that our findings support the need to develop and evaluate a family-centered model of hearing health care wherein the patient is defined as the person with hearing loss and his or her family, key stakeholders are educated about the important role of family members in hearing health care, and wherein audiologists feel confident in being able to address potential conflict between people with hearing loss and their family. It will be important to evaluate intervention outcomes in terms of patient and family functioning and changes to activity limitations and participation restrictions. In addition, service-level environmental impacts (e.g., duration of appointments) will need to be evaluated.

Conclusion

It is clear from the qualitative interviews that there is growing acceptance among audiologists of the importance of promoting partnership with family members during the hearing rehabilitation process, an important first step in embracing family-centered hearing health care. Moving forward, audiologists are encouraged to consider the whole family as their patient. It is only then that audiologists will feel comfortable addressing the needs of both the person with HI and his or her family, and that the full benefits of family-centered care will be realized.

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References

Arango, P. (2011). Family-centered care. *Academic Pediatrics, 11,* 97–99. doi:10.1016/j.acap.2010.12.004

Bamm, E. L., & Rosenbaum, P. (2008). Family-centered theory: Origins, development, barriers, and supports to implementation in rehabilitation medicine. *Archives of Physical Medicine and Rehabilitation, 89,* 1618–1624.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101. doi:10.1191/1478088706qp063oa

Brown, K., Worrall, L., Davidson, B., & Howe, T. (2011). Living successfully with aphasia: Family members share their views. *Topics in Stroke Rehabilitation, 18,* 536–548. doi:10.1310/tsr1805-536

Chia, E. M., Wang, J. J., Rochtchina, E., Cumming, R. R., Newall, P., & Mitchell, P. (2007). Hearing impairment and health-related quality of life: The Blue Mountains Hearing Study. *Ear and Hearing, 28,* 187–195.

Dalton, D. S., Cruickshanks, K. J., Klein, B. E., Klein, R., Wiley, T. L., & Nondahl, D. M. (2003). The impact of hearing loss on quality of life in older adults. *The Gerontologist, 43,* 661–668.

Dillon, H., James, A., & Ginis, J. (1997). Client Oriented Scale of Improvement (COSI) and its relationship to several other measures of benefit and satisfaction provided by hearing aids. *Journal of the American Academy of Audiology, 8,* 27–43.

Dunst, C. J., Trivette, C. M., & Hamby, D. W. (2007). Meta-analysis of family-centered helpgiving practices research. *Mental Retardation and Developmental Disabilities Research Reviews, 13,* 370–378. doi:10.1002/mrdd.20176

Ekberg, K., Meyer, C., Scarinci, N., Grenness, C., & Hickson, L. (2014). Disagreements between clients and family members regarding clients' hearing and rehabilitation within audiology appointments for older adults. *Journal of Interactional Research in Communication Disorders, 5,* 217–244.

Ekberg, K., Meyer, C., Scarinci, N., Grenness, C., & Hickson, L. (2015). Family member involvement in audiology appointments with older people with hearing impairment. *International Journal of Audiology, 54,* 70–76. doi:10.3109/14992027.2014.948218

Ellingson, L. L. (2002). The roles of companions in geriatric patient–interdisciplinary oncology team interactions. *Journal of Aging Studies, 16,* 361–382. doi:10.1016/S0890-4065(02)00071-3

Epley, P., Summers, J. A., & Turnbull, A. (2010). Characteristics and trends in family-centered conceptualizations. *Journal of Family Social Work, 13,* 269–285. doi:10.1080/10522150903514017

Goldenberg, H., & Goldenberg, I. (2013). *Family therapy: An overview* (8th ed.). Belmont, CA: Brooks/Cole.

Grawburg, M., Howe, T., Worrall, L., & Scarinci, N. (2013). A qualitative investigation into third-party functioning and third-party disability in aphasia: Positive and negative experiences of family members of people with aphasia. *Aphasiology, 27,* 828–848.

Grenness, C., Hickson, L., Laplante-Lévesque, A., Meyer, C., & Davidson, B. (2015a). Communication patterns in audiologic rehabilitation history-taking: Audiologists, patients, and their companions. *Ear and Hearing, 36,* 191–204. doi:10.1097/AUD.0000000000000100

Grenness, C., Hickson, L., Laplante-Lévesque, A., Meyer, C., & Davidson, B. (2015b). The nature of communication throughout diagnosis and management planning in initial audiologic rehabilitation consultations. *Journal of the American Academy of Audiology, 26,* 36–50.

Hickson, L., Meyer, C., Lovelock, K., Lampert, M., & Khan, A. (2014). Factors associated with success with hearing aids in older adults. *International Journal of Audiology, 53,* S18–S27.

Howe, T., Davidson, B., Worrall, L., Hersh, D., Ferguson, A., Sherratt, S., & Gilbert, J. (2012). "You needed to rehab … families as well": Family members' own goals for aphasia rehabilitation. *International Journal of Language and Communication Disorders, 47,* 511–521. doi:10.1111/j.1460-6984.2012.00159.x

Ishikawa, H., Roter, D. L., Yamazaki, Y., & Takayama, T. (2005). Physician–elderly patient–companion communication and roles of companions in Japanese geriatric encounters. *Social Science & Medicine, 60,* 2307–2320. doi:10.1016/j.socscimed.2004.08.071

Jansen, J., van Weert, J. C., Wijngaards-de Meij, L., van Dulmen, S., Heeren, T. J., & Bensing, J. M. (2010). The role of companions in aiding older cancer patients to recall medical information. *Psycho-Oncology, 19,* 170–179. doi:10.1002/pon.1537

Kalischuk, R. G., Nowatzki, N., Cardwell, K., Klein, K., & Solowoniuk, J. (2006). Problem gambling and its impact on families: A literature review. *International Gambling Studies, 6,* 31–60.

Kramer, S. E., Kapteyn, T. S., Kuik, D. J., & Deeg, D. J. (2002). The association of hearing impairment and chronic diseases with psychosocial health status in older age. *Journal of Aging and Health, 14,* 122–137. doi:10.1177/089826430201400107

Kuhlthau, K. A., Bloom, S., Van Cleave, J., Knapp, A. A., Romm, D., Klatka, K., . . . Perrin, J. M. (2011). Evidence for family-centered care for children with special health care needs: A systematic review. *Academic Pediatrics, 11,* 136–143. doi:10.1016/j.acap.2010.12.014

Laplante-Lévesque, A., Hickson, L., & Worrall, L. (2010). A qualitative study of shared decision making in rehabilitation audiology. *Journal of the Academy of Rehabilitative Audiology, 43,* 27–43.

Laplante-Lévesque, A., Pichora-Fuller, M. K., & Gagné, J. P. (2006). Providing an Internet-based audiological counselling programme to new hearing aid users: A qualitative study. *International Journal of Audiology, 45,* 697–706.

Manchaiah, V. K. C., Stephens, D., Zhao, F., & Kramer, S. E. (2012). The role of communication partners in the audiological enablement/rehabilitation of a person with hearing impairment: An overview. *Audiological Medicine, 10,* 21–30. doi:10.3109/1651386X.2012.655914

Martire, L. M., Schulz, R., Helgeson, V. S., Small, B. J., & Saghafi, E. M. (2010). Review and meta-analysis of couple-oriented interventions for chronic illness. *Annals of Behavioral Medicine, 40,* 325–342.

Meyer, C., Hickson, L., & Fletcher, A. (2014). Identifying the barriers and facilitators to optimal hearing aid self-efficacy. *International Journal of Audiology, 53,* S28–S37.

Meyer, C., Hickson, L., Lovelock, K., Lampert, M., & Khan, A. (2014). An investigation of factors that influence help-seeking for hearing impairment in older adults. *International Journal of Audiology, 53,* S3–S17.

Nund, R. L., Ward, E. C., Scarinci, N., Cartmill, B., Kuipers, P., & Porceddu, S. V. (2014). Carers' experiences of dysphagia in people treated for head and neck cancer: A qualitative study. *Dysphagia, 29,* 450–458.

O Mahoney, C. F., Stephens, S. D. G., & Cadge, B. A. (1996). Who prompts patients to consult about hearing loss? *British Journal of Audiology, 30,* 153–158.

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: Sage.

Preminger, J. E. (2003). Should significant others be encouraged to join adult group audiologic rehabilitation classes? *Journal of the American Academy of Audiology, 14,* 545–555. doi:10.3766/jaaa.14.10.3

Preminger, J. E., & Lind, C. (2012). Assisting communication partners in the setting of treatment goals: The development of the goal sharing for partners strategy. *Seminars in Hearing, 33,* 53–64.

Preminger, J. E., & Meeks, S. (2012). The hearing impairment impact-significant other profile (HII-SOP): A tool to measure hearing loss-related quality of life in spouses of people with hearing loss. *Journal of the American Academy of Audiology, 23,* 807–823.

Scarinci, N., Meyer, C., Ekberg, K., & Hickson, L. (2013). Using a family-centered care approach in audiologic rehabilitation for adults with hearing impairment. *Perspectives on Aural Rehabilitation and Its Instrumentation, 20,* 83–90.

Scarinci, N., Meyer, C., & Hickson, L. (2015). *Family-centered care in audiological rehabilitation: The perspective of older adults with hearing impairment and family members.* Manuscript in preparation.

Scarinci, N., Worrall, L., & Hickson, L. (2008). The effect of hearing impairment in older people on the spouse. *International Journal of Audiology, 47,* 141–151.

Scarinci, N., Worrall, L., & Hickson, L. (2009). The ICF and third-party disability: Its application to spouses of older people with hearing impairment. *Disability and Rehabilitation, 31,* 2088–2100.

Schilling, L. M., Scatena, L., Steiner, J. F., Albertson, G. A., Lin, C. T., Cyran, L., . . . Anderson, R. J. (2002). The third person in the room: Frequency, role, and influence of companions during primary care medical encounters. *Journal of Family Practice, 51,* 685–690.

Stark, P., & Hickson, L. (2004). Outcomes of hearing aid fitting for older people with hearing impairment and their significant others. *International Journal of Audiology, 43,* 390–398.

Street, R. L., & Gordon, H. S. (2008). Companion participation in cancer consultations. *Psycho-Oncology, 17,* 244–251. doi:10.1002/pon.1225

Thoren, E., Svensson, M., Tornqvist, A., Andersson, G., Carlbring, P., & Lunner, T. (2011). Rehabilitative online education versus Internet discussion group for hearing aid users: A randomized controlled trial. *Journal of the American Academy of Audiology, 22,* 274–285. doi:10.3766/jaaa.22.5.4

van den Brink, R. H., Wit, H. P., Kempen, G. I., & van Heuvelen, M. J. (1996). Attitude and help-seeking for hearing impairment. *British Journal of Audiology, 30,* 313–324.

Wolff, J., & Roter, D. (2008). Hidden in plain sight: Medical visit companions as a resource for vulnerable older adults. *Archives of Internal Medicine, 168,* 1409–1415. doi:10.1001/archinte.168.13.1409

Wolff, J., & Roter, D. (2012). Older adults' mental health function and patient-centered care: Does the presence of a family companion help or hinder communication? *Journal of General Internal Medicine, 27,* 661–668. doi:10.1007/s11606-011-1957-5

World Health Organization. (2001). *International classification of functioning, disability and health (ICF)*. Geneva, Switzerland: Author.

Appendix

Interview Guide

Lived Experience

- To start with today, can you tell me what you see as your role in hearing rehabilitation?
- Can you tell me about the involvement of family members in general during your appointments? How are family members involved in hearing rehabilitation?
- How do you feel about the involvement of family members in hearing rehabilitation? Can you tell me how you think people with hearing impairment feel about their family members being involved (e.g., coming to appointments)? Can you tell me how you think family members feel about being involved?
- What are the benefits or advantages of involving family members in hearing rehabilitation? Tell me more. What are the disadvantages of involving family members?
- What sorts of things do the people with hearing impairment talk to you about during appointments? What sorts of things do family members talk to you about?
- In what situations is it easier to involve family members in hearing rehabilitation? In what situation is it more difficult to involve family members in hearing rehabilitation?
- In your experience, how does the involvement of family members affect outcomes for people with hearing loss? And how does the involvement of family members affect outcomes for family members?

Service

- Can you describe how you set goals with your clients? Have you considered setting joint goals for the person with hearing impairment and their family? Tell me more.
- In an ideal world, how do you think family members should be involved in hearing rehabilitation?
- In your practice, what do you do to involve family members?
- What factors in your service help facilitate the involvement of family members? What factors do you feel prevent or limit family member involvement?

Knowledge

- What knowledge do you think people with hearing impairment have about hearing loss/hearing aids/communication difficulties? What knowledge do you think family members have?
- What knowledge do you think they should have? Tell me how you try to bridge this gap.
- What do you think happens with this knowledge?

Roles and Responsibilities

- What do you think your role should be with the person with hearing impairment? Describe what you see as your role with family members in hearing rehabilitation.
- How do you feel about providing advice or counselling about communication difficulties to the person with hearing impairment and their family? Tell me more.
- Who do you view as the client in your practice?
- What role do you see the person with hearing impairment as having? How do you help them accept their role?
- What role do you see family members playing? How do you help the family member accept their role?
- How do you feel about working with couples in hearing rehabilitation to address their needs?