

Family-centered Audiology Care: Working with Difficult Conversations

Recommendations for moving toward a family-centered model in hearing healthcare

By KRIS ENGLISH, PhD; MARY BETH JENNINGS, PhD; CHRISTOPHER LIND, PhD; JOSEPH MONTANO, EdD; JILL PREMINGER, PhD; GABRIELLE SAUNDERS, PhD; GURJIT SINGH, PhD; ELIZABETH THOMPSON, AuD

A family-centric approach to hearing healthcare must acknowledge the fact that discord and disagreement about the severity and importance of the hearing loss can occur between the patient and his/her family members. When parties are in disagreement, difficult (but important!) conversations can arise. This article presents four strategies and examples for handling these conversations, while pointing to a need to acquire “difficult conversation competencies.”

Editor’s note: As reported in The Hearing Review online news (November 6, 2015), Phonak has convened a select group of hearing healthcare experts to provide evidence-based recommendations to hearing care providers on how to better engage family members. The objective of this group is to facilitate family involvement throughout the hearing remediation process. The first installment, “Family Centered Adult Audiologic Care: A Phonak Position Statement”,¹ appeared in the April 2016 Hearing Review. This is the second paper from the group’s work.

Difficult conversations are a part of everyday life, involving people we work with, live with, and care about.² Audiology certainly has its share of difficult conversations, perhaps epitomized by the responsibility of informing parents of a child’s hearing loss.³ Other examples of difficult conversations in audiology include:

- Explaining to a teen patient that her hearing loss is indeed permanent;
- Acknowledging the impact of stigma with a patient who dreads appearing old, infirm, or unattractive;
- Calibrating high expectations with realistic outcomes.



We may feel generally prepared for these kinds of conversations because they are part of our daily one-on-one patient encounters. However, when a family member is included, the complexity of the conversation inherently increases and may catch us off guard. Consider an example shared by a student who was assessing a patient with tinnitus, but had not expected the husband to express his own concerns: “The husband, while being caring and defensive for his wife, tried time and time again to get information....‘What is causing this? What is the likelihood of it getting better? Why are you passing us off to the physician? Why won’t you give us answers?’ I [the



Kris English, PhD, is Professor/Interim School Director at the University of Akron/NOAC, Akron, Ohio; **Mary Beth Jennings, PhD**, is Associate Professor of the School of Communication Sciences and Disorders at the University of Western Ontario, Canada; **Christopher Lind, PhD**, is Senior Lecturer in Audiology in the Department of Speech Pathology and Audiology at Flinders University, Adelaide, Australia; **Joseph Montano, EdD**, is Associate Professor of Audiology and Director of Hearing and Speech at Weill Cornell Medical College, New York Presbyterian Hospital; **Jill Preminger, PhD**, is Division Chief of Communicative Disorders and Program Director for Audiology at the University of Louisville School of Medicine, Louisville, Ky; **Gabrielle Saunders, PhD**, is Associate Director of the VA RR&D National Center for Rehabilitative Auditory Research (NCRAR) and Associate Professor in the Department of Otolaryngology at Oregon Health and Science University, Portland, Ore; **Gurjit Singh, PhD**, is a senior research audiologist at Phonak, Warrenville, Ill; and **Elizabeth Thompson, AuD**, is Director Business Development, VA and Audiology, at Phonak.

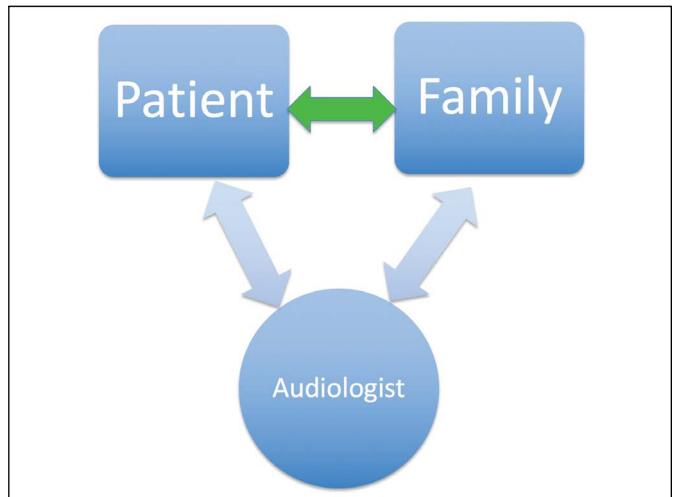
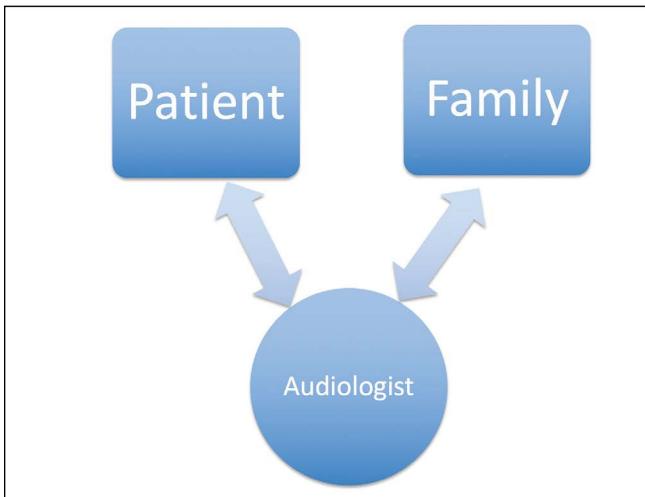


Figure 1. Let the patient and family member know that input will be sought from both of them: patient first, and then family member.

Figure 2. As the conversation moves forward, the audiologist can attempt to reframe a difficult conversation item and help the patient and family member(s) build accord and find positive solutions.

student] had not appropriately devoted time to helping the husband understand my role in the process. He heard my suggestions for technology and other options, but he had not heard me validate his or his wife’s personal journeys.”⁴

As a reflective-practitioner-in-training,⁵ the student realized that, of course, family members will have concerns, and they will want to be *included* in the appointment. This realization doesn’t necessarily help us feel comfortable with the prospect, because there are still so many unknowns: What if patient and family perspectives contradict? Can we help patient and family develop common ground? What if the family member takes the lead or even dominates the conversation? Will we lose control of the appointment? Wouldn’t it be better to avoid the situation altogether?

These are the kind of questions that could lead audiologists to opt out of “family-centered” audiologic care, even in light of several known benefits. Singh et al¹ recently published a position paper regarding the benefits or why’s of family-centered care: to benefit the patient, the family, the clinician, the business, and the relevance and longevity of the profession. The position paper also offered 10 suggestions on how to implement family-centered audiologic care. The three they recommend starting with are:

- 1) Invite a family member to appointments and reinforce the reasons why they should attend;

- 2) Arrange the physical environment so that family are comfortably included rather than being relegated to a seat in the back of the room;
- 3) Let the patient and family member know that input will be sought from both of them: patient first and then family member (Figure 1).

This last suggestion will inform us whether the patient and family are on the same page regarding the patient’s hearing problems. If they both see the situation the same way—and both are open to our help—we can move forward. However, when the parties are not in agreement, we likely find ourselves in a difficult conversation. Let us consider a scenario wherein a patient (Mr Roberts) and his son are present for an appointment:

Audiologist: It’s nice to meet you, Mr Roberts. And you are?

Son: I’m his son, Joseph.

Audiologist: Welcome to you both. Mr Roberts, I’d like to focus on you first, and then, Joseph, I’m hoping you will add your thoughts? [Joseph nods; audiologist turns back to Mr Roberts]. Mr Roberts, tell me about yourself... [He introduces himself and talks about his occupation, family, interests, etc] This is all helpful to know. And now, what brings you here today?

Mr Roberts: [rolling his eyes] Joe did—he made this appointment and he also drove me here. He’s making a big fuss about nothing.

Son: [Leans in, and the audiologist turns his way.]

Audiologist: What’s your take on the situation, Joseph?

Son: He keeps saying that, but it’s not true. He is really missing almost everything people say these days.

Mr Roberts: And yet I’m understanding him perfectly right now. I’m an old man; it’s normal to stop listening to every silly word.

We realize we have opened the proverbial “can of worms,” a concern shared by other healthcare professionals as well.⁶ The patient is defensive and feels demeaned; the son is concerned and frustrated. We’ve learned their conversation has been going on for some time, and has not been productive.

Our first instinct might be to withdraw from the uncomfortable situation, bypass the familial tension, and focus only on the patient.⁷ However, this approach would likely yield only short-term gains: we might maintain some efficiency in terms of testing time, but our test results and recommendations may not help the patient change his viewpoint. He has taken a position and, human nature being what it is, will hold on to it: “Once one has made a public pronouncement, matters of pride and consistency push one toward clinging to that position, no matter how discredited.”⁸

Rather than avoid this difficult conversation, we can take an extra step and try to help the patient reframe the situation, ideally from his son’s point of view. To do so, the conversational flow needs to change, so the audiologist seeks a way to help them talk to each other, not to her (Figure 2).

Audiologist: You've talked about this before [they nod] and it's become a sore spot? [They nod again.] Let's change gears a bit: it would help me to learn a little bit about what is important to you as a family. What kind of things do you do together?

Mr Roberts: Not much together these days. I'm retired now and Joe works. But I fill in as babysitter a lot; I've got three grandchildren, they keep me going.

Son: They love hanging out with you. Yesterday I told them about how you and I used to fish together on weekends, and they said they'd like to try that.

Mr Roberts: That would be great... [He makes eye contact with the audiologist but she waits for Joseph to finish his thought.]

Son: But Dad, maybe you don't realize why we stopped doing it. When we'd fish, we'd also talk for hours—well, whisper, of course. To me, that really was the best part. But the last time we fished, I had to raise my voice for you to hear me—practically shouting—and that kept the fish away. We didn't catch a thing and we just stopped trying.

Mr Roberts: [Facial expression changes, realization sets in. The audiologist waits again, resisting the impulse to take control of the conversation.]

Son: This is what I'm getting at, Dad. It's not about fishing. I like talking with you; I want you to hear me, hear the kids.

Mr Roberts: [Nods.] Those were good times. Fair enough. I guess I can give it a try. [He and Joe turn to the audiologist.] Where do we start?

Initially, the audiologist's ability to help was blocked by family emotions (defensiveness, frustration). We cannot directly change those emotions, but we can provide opportunities to help both parties talk to each other about what hurts, what matters, and what they want. Try as we might, there is no avoiding this truism: feelings are at the very core of these difficult conversations.² It may seem efficient to leapfrog over emotions into problem-solving mode, but rushing the process is counterproductive since, ultimately, "unacknowledged feelings do not disappear. They fester."⁹

What Helped This Difficult Conversation?

The audiologist carefully employed four behaviors to advance this conversation:

1) Acknowledging the emotions in the room. "You've talked about this before and it's become a sore spot?" It is tempting to overlook the tension in an appointment and stay in our "comfort zone" (testing and explaining results). However, when we do so, we risk patient disengagement and the decision not

to adhere to our recommendations.^{10,11} Our opportunities to earn patient trust are few and time-constrained, but we can optimize the opportunities by honestly addressing patient and family emotions.

2) Using open-ended queries. "What kind of things do you do together?" This question is an invitation to both parties to co-develop the family story. The initial responses may not include listening challenges, but soon the son will allude to the reason for the appointment: there are times when hearing problems have impacted the quality of their family lives.

3) Providing the opportunity to reframe the situation in the family's own words. The open-ended query allowed Joseph to explain how his father's hearing loss has affected him and their relationship. Family members often focus on what frustrates them (the patient won't answer the phone, turn down the TV, or admit there is a problem), resulting in accusations and resentment. Family members may not yet have articulated why they are frustrated: the quality of their family life is diminishing, and because the patient doesn't seem to care, it feels like rejection.

When reframed as a quality-of-family-life concern rather than a personal failure, the patient is more likely to see the situation within the family context and realize, "I had no idea that this is what *you* were experiencing." This kind of revelation can provide motivation for moving forward.

4) Waiting. When Mr Roberts makes eye contact, he is expecting the audiologist to take over the conversation, but she can tell Joseph still has more to say, and she waits for him. Reviewing the dialogue, we can appreciate how much would *not have been said* had she jumped into the conversation at that point. Waiting is probably a more professionally congruent concept for audiologists than "clinical silence" as employed by professional counselors, because it feels comfortable and courteous.

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We merely elect to slow down, observe the other speaker, and determine if he has more to add but needs time to gather his thoughts, or is somewhat overwhelmed and needs time to compose himself. At a later point, the audiologist waits again; from his facial expression, she gathers that Mr Roberts needs a moment to process what his son is saying.

Our experience tells us not all family conversations are as straightforward as this example. The first challenge we have addressed here is engaging both patient and family member in a conversation that quickly gets to the "heart of it all." But additional complications can surface as well, for instance the misconceptions that both parties may have about hearing loss.

Son: He says he can't hear on the phone and so he never takes messages for me. Sometimes when we are home he just doesn't answer me. Then I hear him having a great old chat and laugh with his mate over the phone.

Mr Roberts: Some voices are easier to follow than others. Bob has a voice that I can hear over the phone. I have known him for 35 years.

Son: You can hear when you want to. You just ignore me. [Mr Roberts throws himself against the back of his chair, crosses his arms, and glares at the wall clock, appearing angry and hurt.]

Audiologist: [Acknowledging Joseph:] That's what it feels like to you... [Facing Mr Roberts:] Would you say that's the whole story? [He shakes his head.]

[Speaking to both:] So there's more to it, but we don't know what that is yet, exactly. Let's find out.

Our starting point is to evaluate Mr. Roberts' hearing. Next, *as a team*, we want to understand just how complicated hearing and hearing loss is. It can look like "selective listening," which upsets those feeling ignored. [Joseph nods emphatically.] But that's just the tip of the iceberg. [Mr Roberts slowly nods, realizing he doesn't know what else the "iceberg" entails.] Several situations add even more stress to hearing abilities—even soft music in the background, or a change in our overall health.

[Addressing Mr. Roberts:] You can teach us about this. Your thoughts?

Mr Roberts: It would be great to find out what is actually going on.

Son: [Nods with relief.] Whatever it takes, Dad.

As before, the audiologist first took a moment to recognize each person's emotional reactions. By giving credence to both experiences, as well as providing a brief preview of

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future “family education” sessions, she helped the family move beyond its stressful impasse.

A New Framework for Audiology: The Family is the Patient

Obviously, not all families are healthy and supportive, and not all patients are interested in restoring family relations. We know from experience that some families will not agree on much, including the impact of hearing loss or the need for hearing help. Sometimes family members disengage from the process altogether. Obviously, audiologists are not family counselors.¹² However, it’s the rare patient who has no “family” in his or her life (in the broadest definition, to include friends and communication partners, per Singh et al¹), and we cannot deny the impact supportive families can have on patient success.¹³ As complicated as families might be, we would be remiss to exclude them from patient care. As a first step in understanding family-centered care, we could contemplate a basic principle already consistently applied in pediatric audiology¹⁴: that in family-centered care, the family is the patient.^{15,16}

When the family is our patient, our outcome questions change accordingly: Is the family happy, satisfied, generally adjusting well? To date, we do not have a valid way in audiology to answer these questions.

Where Do We Go From Here?

Not surprisingly, managing difficult conversations requires advanced skills. For instance, Browning et al¹⁷ describe a set of “difficult conversation competencies” which includes:

- Comfort with our own imperfection and vulnerability;
- Expecting—not avoiding—uncertainty, ambiguity, and complexity.

Readers will likely agree that these personal characteristics are not typically discussed in audiology. The lack of attention to “who we are” and the issues of control and power in these encounters probably explains a comment the first author recently heard at

a conference: “...As long as they (patients/families) think they are getting their way...”

The encouraging news is, becoming comfortable and effective with difficult conversations is a teachable and learnable skill.¹⁸⁻²⁰ There is much more to learn as well, and future articles will contribute to our understanding of family-centered care in audiology. ■

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CORRESPONDENCE to Dr English at: ke3@uakron.edu. To learn more about the Family-centered audiology care initiative, email Ora Buerkli-Halevy at: ora.buerkli@phonak.com