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ORIGINAL ARTICLE

Audiologists' views on patient empowerment in hearing rehabilitation: a focus group study

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ABSTRACT

Objective: This study investigated how audiologists interpret empowerment dimensions (knowledge, skills and strategies, participation, self-efficacy, and control) in relation to their patients and practice, and how these dimensions are integrated into practice.

Design: A qualitative focus group study with five groups. Data were thematically analysed.

Study sample: Audiologists engaged in hearing rehabilitation in Sweden, representing public and private sectors, with minimum three months' full-time experience.

Results: The results highlight audiologists' role in individualised knowledge transfer. They facilitate development of essential skills and strategies through proactive assessment, tailored communication, and guidance. Patient participation is viewed as important yet complex, shaped by readiness and contextual factors. Approaches are adapted to promote meaningful engagement, recognising participation is not always straightforward or beneficial. Self-efficacy and sense of control are acknowledged as important but remain less emphasised in daily practice compared to knowledge, skills and strategies.

Conclusions: Audiologists view empowerment as a shared goal between clinician and patient. To support empowerment, both should reflect on its dimensions and ensure each is addressed in care. Findings underscore the multifaceted nature of empowerment and the nuanced clinical role required to foster it. No single approach fits all, highlighting the need for person-centred care to support patient outcomes.

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Introduction

Empowerment in a health context is defined as "a process through which people gain greater control over decisions and actions affecting their health" (World Health Organization 1998). For individuals experiencing chronic illness, the literature increasingly points to a relationship between patient empowerment and positive health outcomes (Anderson et al. 1995; McAllister et al. 2012; Stepanian et al. 2023). This research suggests that a feeling of empowerment may increase chronic illness patients' autonomy, self-management, and coping abilities (Cerezo, Juvé-Udina, and Delgado-Hito 2016). Hearing loss is a long-term condition that can limit a person's ability to communicate, participate socially, and maintain a high quality of life (World Health Organization 2004). Positive outcomes related to empowerment seen in other chronic disorders (Anderson et al. 1995) are therefore likely to be relevant for people with hearing loss. However, up until recently, there is only a small collection of empirical research that examines the intersection of empowerment and hearing loss in adults (Ferguson et al. 2026; Gotowiec et al. 2022), and even fewer studies that also incorporate audiologists (Bennett et al. 2021; Laplante-Lévesque et al. 2013).

Zimmerman's (1995) theory of psychological empowerment defines empowerment as a multidimensional construct comprising intrapersonal, interactional, and behavioural components. These refer to individuals' beliefs in their ability to influence their environment, their understanding of that environment, and their actions to effect change. The framework views empowerment as a process of gaining mastery over personally relevant issues, leading to a sense of control (Zimmerman 1995). However, its expression varies by context, highlighting the need to define empowerment and its dimensions in population-specific terms.

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Gotowiec et al. (2022) answered the call for a hearing health population-specific definition of empowerment by qualitatively exploring how empowerment manifests for individuals on their hearing health journey from first becoming aware of their hearing loss through to being fit with hearing aids and becoming an active hearing aid user. Their conceptualisation of empowerment from the perspective of the individual with hearing loss, based on the Zimmerman theoretical framework, was as follows:

> Empowerment along the hearing health journey is the process through which individuals with hearing-related challenges acquire and use knowledge, skills, and strategies, and increase self-efficacy, participation, and the feeling of control of their hearing health care, hearing solutions, and everyday lives.

Although no previous work has specifically investigated these five empowerment dimensions (knowledge, skills and strategies, participation, self-efficacy, and control) together in relation to audiologists and their patients, prior literature has examined these concepts individually. For example, research suggests that knowledge about hearing loss, possible management options and rehabilitation prospects, and the skills related to managing these factors are independently related to enhanced coping abilities and a general feeling of empowerment (Convery et al. 2016; Laplante-Lévesque et al. 2013). The delivery of information and knowledge is a central part of this relationship (Grenness et al. 2014), as is encouraging skill development (Barker, De Lusignan, and Cooke 2018) and ensuring that communication strategy development is part of the clinical hearing rehabilitation process (Wänström et al. 2014). In relation to participation, the decisions involved in seeking clinical help and choosing a hearing aid are an important aspect (Knudsen et al. 2013). Furthermore, this form of shared decision-making is a central facet of empowerment in patient-audiologist interactions (Poost-Foroosh et al. 2011; Pryce et al. 2016). Self-efficacy, the belief in one's own ability to perform a given task or behaviour, has a positive relationship with hearing aid uptake and better rehabilitation outcomes (Ferguson, Woolley, and Munro 2016; Hickson et al. 2014). In addition, previous audiological work indicates that hearing-related challenges can manifest as a loss of control over hearing-related aspects of an individual's life (Carson 2005), but that hearing aids (Ferguson et al. 2026; Gotowiec et al. 2022), and hearing-related smartphone apps (Gomez et al. 2022) may help individuals gain a sense of control over their hearing challenges. Further, individuals who feel a sense of internal control may use their hearing aids more frequently (Cox, Alexander, and Gray 2005), and may report a lower hearing handicap (Garstecki and Erler 1998). In summary, previous research suggests that empowerment and its dimensions can lead to positive outcomes for this patient population. As the hearing rehabilitation process is a dual experience between patients and audiologists, empowerment can be framed as a shared goal between these two parties. In healthcare in general, the patient-provider interaction is of central importance in the empowerment process (European Patients' Forum 2017). Previous audiological work supports this statement, noting that empowerment is an important aspect of the patient-audiologist dyad. Audiologists can promote empowerment by passing on knowledge, supporting the development of skills and strategies, and using shared decision-making techniques to promote patient participation (Bennett et al. 2021; Poost-Foroosh et al. 2011). While patient empowerment has been discussed in audiology, clinicians' interpretations and applications of its dimensions remain underexplored. It is therefore important to scope how audiologists view the empowerment dimensions, their role in the empowerment process, and how they factor in the empowerment dimensions in their work with patients. While Gotowiec et al. explored empowerment from the patient perspective, this study looks at audiologists' interpretation of empowerment in relation to their patients and practice, and how these dimensions are integrated into clinical work.

The current study takes a qualitative approach to explore these perspectives. In hearing health research, qualitative research is increasingly common. This approach helps to drive a more complex and inclusive understanding of the multifaceted elements of hearing health (Knudsen et al. 2012). Qualitative methods contribute to our understanding of the experience of hearing loss, the use of hearing aids, and healthcare in the hearing domain. This type of research adopts an open-ended approach, which allows for deep examinations that attempt to *understand* a phenomenon as opposed to *measuring* it (Green and Thorogood 2018). While there is a growing body of audiological research using qualitative methods, there is less work that focuses on the hearing rehabilitation process itself, for example how personal interactions with clinicians affect patients' hearing rehabilitation (Laplante-Lévesque et al. 2013). Here, we approach this topic from the perspective of the audiologist and their thought and decision processes around their patient interactions.

The aim of this study was to investigate how audiologists understand and act in their daily clinical practice in relation to the five previously identified dimensions of empowerment (knowledge, skills and strategies, participation, self-efficacy, and control) on the hearing health journey (Gotowiec et al. 2022). The central research topics were as follows:

i. What do the dimensions of empowerment mean to audiologists in relation to their patients?
ii. How do audiologists factor the dimensions of empowerment into their clinical practice?

Table 1. Demographic data.

Variable	Mean	Range
Age (SD)	41.32 (12.63)	25–61
Working experience, years (SD)	11.87 (10.58)	1–38
	n	%
Gender		
Male	4	21.05
Female	15	78.95
Employment form		
Publicly funded	13	68.42
Privately owned clinic	6	31.58
Size of working place, persons		
≤5	6	31.58
≥6–≤15	4	21.05
>15	9	47.37
Working in interdisciplinary teams		
Yes	9	47.37
No	10	52.63

Materials and methods

The study was approved by the Swedish Ethical Review Authority (dnr: 2020–04562).

The study is reported in accordance with the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al. 2014). The checklist is provided as supplementary material.

Participant sampling and recruitment

For the current study, data collection through focus groups was chosen as this method is well suited for exploring experiences, beliefs, opinions, and concerns (Kitzinger 1995) when the goal is to ask participants to share and compare their experiences with one another, and explore issues of shared importance (Breen 2006). Focus groups have been used in previous audiological research investigating aspects of the patient-audiologist interaction (Laplante-Lévesque et al. 2013), but not the empowerment process. In total, we conducted five focus groups with 3–5 participants each (Team 1: $n = 4$, Team 2: $n = 5$, Team 3: $n = 3$, Team 4: $n = 3$, Team 5: $n = 4$). 19 audiologists (4 males) were included in data collection. The sample size was considered sufficient in relation to the concept of information power (Malterud, Siersma, and Guassora 2016), given the focused aim, specific participant group, and richness of the focus group data. The mean age was 41.3 years (range = 25–61 years) and mean experience working with hearing rehabilitation was 11.9 years (range = 1–38 years). See Table 1 for further demographic information. All participants were audiologists with at least three months of full-time experience who currently worked with hearing rehabilitation. The participants were recruited through purposive sampling, targeting audiologists working with rehabilitation in Sweden across both public and private organisations. Purposive sampling was used to ensure that individuals with relevant experience were included and to obtain variation in gender, years of clinical experience, and sector affiliation, characteristics that could shape rehabilitation practice (Creswell and Poth 2017). Sources for recruitment were contact information from the "Hörselvårdsregistret" (hearing care register) a national database where audiological professionals voluntarily register, and direct emails to clinics (managers and staff). All participants provided written informed consent and received 50 EUR for their participation.

Procedure

Each of the focus groups took place over Zoom. Group configurations were randomly determined. After enrolling in the study and prior to data collection, informed consent and demographic information were collected via postal mail. At the focus group sessions, each participant was presented only by first name for confidentiality. The sessions were recorded with two recording devices, and the moderator (author JL) took field notes during each session. Each of the five focus group sessions lasted between 87 and 150 min, with an average length of 120 minutes (SD = 24.85). After providing participants with general project information, focus group guidelines, and a session overview, the recording was started. Participants were asked not to search for information or use other apps or equipment during the session to ensure full engagement. Data collection took place over three weeks between March and April 2021. Prior to commencing data collection, two pilot groups were conducted on site. After the pilot groups, the planned group size was reduced to 3–5 people instead of the planned 4–6 (Dos Santos Marques et al. 2021) to

facilitate online data collection, as the format changed from in-person to online during the COVID-19 pandemic. The online format facilitated the inclusion of participants from different geographical locations within Sweden. The topic guide was developed specifically for the study (see Supplementary Materials) and included open-ended questions based on the empowerment dimensions described by Gotowiec et al. (2022). Follow-up prompts were used to encourage more thoughtful responses. The guide began with introductory questions to build rapport, before the actual data collection was initiated. Next, empowerment was introduced first as a general concept, then in the context of hearing. Finally, each empowerment dimension was presented, to allow participants to reflect on them individually.

Data analysis

All interviews were conducted in Swedish and professionally transcribed verbatim, excluding non-verbal utterances (Braun and Clarke 2006). Transcripts were coded using NVivo 13 (QSR International 2020). Author JL reviewed each transcript while listening to the recordings to ensure transcription accuracy (Braun and Clarke 2006). Names and places were anonymised. A constructivist approach guided both data collection and analysis, aiming to explore how audiologists perceive empowerment in patient interactions, based on "qualitative materials that are narrative and subjective" (Polit and Beck 2017). Data were coded in the original language (Swedish) and analysed using thematic analysis, suited to a wide variety of research questions and topics that aim to identify and analyse themes within collected data, usually for interview and focus group data (Braun and Clarke 2006, 2012). Codes were formed to capture all aspects of the content and meaning units expressing multiple concepts were coded accordingly. The coding process included both manifest and latent coding. Manifest coding identifies themes based on what a participant has said, through descriptively summarising the data without interpreting or assigning a meaning (Patton 2002). Latent coding explores underlying meanings beneath the semantic surface by unpacking the ideas and theoretical constructs that underlie the data, in this case using the empowerment framework (Gotowiec et al. 2022) to guide and interpret the analysis (Cash and Snider 2014).

The coding process was initially inductive, allowing codes to be generated from the data. This was followed by a deductive step, where codes were organised in relation to the existing empowerment framework and research questions (Braun and Clarke 2006). Codes that did not clearly align with the framework were discussed between the authors and either incorporated where they contributed to understanding the study aim or not carried forward into the final thematic structure.

The relevant codes were sorted into the dimensions outlined from the prior conceptualisation of empowerment (Gotowiec et al. 2022): knowledge, skills and strategies, participation, self-efficacy, and control. From there, the codes were clustered into themes and subthemes. All coding was performed by researcher JL. Co-researcher SG read all interview transcripts and engaged with a subset of the data, contributing to the development and refinement of themes and subthemes through discussion with JL. These discussions were used to challenge and further develop the analysis. The authors have professional backgrounds in audiology and psychology, with prior experience in empowerment research. The first author (JL), who conducted the focus groups and primary analysis, had no prior relationship with participants, which may have facilitated open discussion. JL's clinical background informed the focus of follow-up questions and supported the interpretation of what participants said, particularly in identifying clinically relevant aspects of empowerment. The involvement of a co-researcher with a different disciplinary background supported ongoing discussion and helped to broaden and challenge interpretations. Reflexivity was maintained throughout the analysis, including ongoing discussions between the authors to reflect on and challenge interpretations.

Results

The thematic analysis drew on five themes corresponding to the five dimensions of empowerment identified in previous work (Gotowiec et al. 2022). For an overview of all themes and subthemes, see Table 2.

Knowledge

In this theme, participants discussed their views on knowledge in relation to hearing in general, the wide range in patients' pre-existing knowledge, and the audiologists' various roles in communicating and disseminating knowledge and information. In the subtheme *meaning of having hearing-related knowledge,* participants described the importance of patients

Table 2. Key themes and subthemes.

1 Knowledge
1.1 Meaning of having hearing-related knowledge
1.2 Assessing what knowledge is needed
1.3 Audiologist as a knowledge and information distributor
1.4 Ways to communicate information
2 Skills and strategies
2.1 Meaning of having or developing skills and strategies as tools for self-management
2.2 Ways to develop skills & strategies
2.3 Audiologists' roles
3 Participation
3.1 Meaning of participation in hearing rehabilitation
3.2 How patients signal participation
3.3 Facilitating participation
3.4 Patient is not included in certain decisions
3.5 Over-engagement seen in some patients
4 Self-efficacy
4.1 Reflecting on self-efficacy
4.2 Signs of self-efficacy
4.3 Strengthening self-efficacy
5 Control
5.1 Ambiguity and variability of control
5.2 Signs of control
5.3 Framing when discussing control
5.4 Enhancing perceived control through clarity and empathy

having broad knowledge across multiple areas including hearing, relevant technology, sound environments, and the overall hearing rehabilitation process. They expressed that having appropriate information and knowledge is vital to form realistic expectations about their hearing and rehabilitation. As one participant described:

> Maybe it's easier for the patients to deal with it when they know… … why they are behind the ball in the next conversation. (P5)

The participants experienced that the degree of knowledge patients possess before entering hearing rehabilitation varies widely. In *assessing what knowledge is needed*, they described the importance of identifying what the patient already knows and what they still need to learn to support their ongoing rehabilitation. They pointed out the need to evaluate and carefully select the information and knowledge to be conveyed to patients. This is done by mapping patients "*needs, background and wishes*" (P11) and assessing patients' knowledge levels both by asking directly and by observing patients' reactions when information is provided. Participants also shared their observation that a lack of knowledge about hearing, hearing loss and hearing aids is not limited to patients but is also common among relatives and society at large. This was also reflected in participants' views on the broader context:

> Also that one's close circle and surrounding others or society at large needs to gain more knowledge about hearing loss. (P12)

Participants perceived that they have a significant and important role in imparting knowledge. The *audiologist as a knowledge and information distributor* subtheme encompasses insights about audiologists as experts who must convey their own competencies and adapt to the patients' individual needs and expectations. They make continuous decisions about what information should be conveyed to their patients and they have clear intentions behind the specific content they share, often to help increase patients' motivation and to set expectations. The participants acknowledged that a substantial amount of information needs to be shared during the hearing rehabilitation process, and they emphasised their role(s) in assessing the information suitable for each individual patient.

> And try to understand the patients and assess what is appropriate information and knowledge for the particular patient. (P8)

Participants also mentioned the importance of tailoring information for a specific occasion, for example, when explaining what the patient is entitled to (e.g. access to hearing aids or rehabilitation services within the healthcare system), why hearing aids are important, what it means to live with hearing loss, and the advantages and disadvantages of the choices the patient makes. In terms of being able to deliver information and knowledge to patients, the participants also elaborated on the importance of having professional skills, and remaining updated, for example on the latest technological offerings in the field.

> Today, it is very important that you are up-to-date on the new technology that is coming out at a rapid pace. So sometimes it becomes difficult to keep up. (P10)

Ways to communicate information describes how information and knowledge are delivered by adapting the method of communication, as well as the content and amount of information. Some participants shared that they standardise certain information by using checklists to ensure that all patients receive the same important information. However, some participants also described the importance of flexibly adapting the order in which information is presented, as well as selecting which information to omit and which to focus on. For example, technology-related information may be more effectively shared after the patient has understood their hearing situation. Participants also brought up the value of repeating information to consolidate knowledge. Finally, group-delivered pre-information (i.e. group sessions where patients receive

introductory information before individual appointments) was described as a successful part of the clinical knowledge-building process. Participants highlighted this with examples from practice:

> There you notice quite a big difference between the patients who have been to the group pre-information … …. It goes quicker with those who have been." (P15)

Skills and strategies

Patients use skills and strategies to manage their hearing, hearing devices, and communication with others. These include, for example, communication strategies (e.g. positioning oneself in conversations), practical handling of hearing aids (e.g. changing batteries or cleaning devices), and ways of managing challenging listening environments. Within this theme, participants talked about the skills and strategies patients possess and acquire, and how they think about their role in helping patients to develop in this domain. In the subtheme *meaning of having or developing skills and strategies as tools for self-management*, participants described the importance of patients having different strategies in different environments. Further, the need to develop specific strategies can be different depending on the degree of hearing loss. In the participants' experience, patients that have existing strategies or are open to learning them are more motivated and receptive to hearing rehabilitation, which ultimately facilitates an audiologist's work. Conversely, participants reported that when patients lack strategies, it can be an explanation for something related to their hearing challenges being difficult. Through their clinical work, participants have observed that having or developing hearing-related skills and strategies in everyday life can have a substantial impact on the day-to-day life of a patient living with hearing loss. Skills and strategies can help patients to manage everyday life, resolve conflicts in relationships, cope in social contexts, and facilitate communication.

> It doesn't help with a hearing aid if you stand on different floors and shout to each other … … and then just: aha, but I haven't thought of that. So simple hints just to make it work in everyday life. (P5)

When sharing about *ways to develop skills and strategies*, participants noted that skill and strategy acquisition often occurs gradually throughout the hearing journey. Sometimes, patients unconsciously use strategies, for example lip-reading, whereas others are more aware of their needs in conversation, such as positioning themselves on a specific side of a speaker. Participants emphasised that a prerequisite for learning skills is often to allow the patients to try for themselves, such as practicing program and batteries changes, cleaning their devices, or replacing for example wax filters or domes. Additionally, one participant shared that patients also learn strategies by trying themselves. As one participant noted:

> It can be a bit difficult sometimes as a patient to use them [strategies], they have to try them out and see what works and what doesn't. (P4)

Audiologists' roles in teaching skills and strategies vary, and how they perceive their roles also vary. Participants shared that they first observe patients' current level of skills and strategies to determine how to begin addressing the topic. In many cases, patients' existing use of hearing-related skills and strategies seems to indicate their level of motivation when entering hearing rehabilitation and being fitted with hearing aids. Furthermore, participants described their role in raising patients' awareness of strategies, with some doing this explicitly through direct conversations with patients.

> I talk about it a lot. Like what strategies to use and how to use them and so on. (P4)

Some participants felt that these discussions are easier to initiate with patients who are experienced device users, who can more clearly describe specific challenges, or when there is a strong relationship between audiologist and patient. Another subset of participants mentioned that they only introduce strategies later in the rehabilitation, often during conversations evaluating hearing devices. Among those who explicitly address skills and strategies, some noted that involving relatives can facilitate discussions. Various approaches to these discussions were described, including practical training in hearing aid handling, role-playing exercises, drawing on patients' own stories, or posing open-ended questions to spark reflection. Conversely, others explained that they do not address strategies and skills directly but instead approach the topic more implicitly through conversations about motor skills or patients' behaviour in different situations.

> I usually try to ask as well … if they have difficulty in meetings and such, that you ask, like: how do you usually handle that? Do you tend to think about how you position yourself? Such things, already there it is possible to have a discussion on how to think strategically around their hearing. (P8)

Participation

Participation in relation to hearing rehabilitation refers to the active involvement in the decisions, processes, and actions on the hearing health journey including interactions with the audiologist. In this theme, participants discussed several aspects of participation, including how they facilitate it, how they perceive patients' engagement, and how they understand participation from a clinical perspective. In the subtheme *meaning of participation in hearing rehabilitation*, participation was described as important for fostering commitment, motivation, hearing aid use, and understanding of hearing aid handling and available choices. It was also described as central to the collaborative work between audiologists and patients. Ensuring that patients feel involved was framed as both a prerequisite for, and a goal of, hearing rehabilitation. Factors described as influencing participation included motivation, perceived need for rehabilitation, voluntary attendance at the clinic, cultural background, and level of education. Participants noted that these factors could shape how actively patients engaged in the rehabilitation process, for example in terms of asking questions, expressing preferences, or taking initiative during visits. Participants described variation rather than consistent patterns, and no single factor was associated with a specific level of participation. This is further complicated by the fact that individuals express participation in different ways, and it is not standard practice to ask patients directly whether they feel involved.

> You really need to ask the patients. Sometimes you assume they know, but you always must ask. Of course, we have this [post-rehabilitation survey] and there I think they have such questions, but I'm actually going to go and ask what our patients answer to that." (P6)

In *how patients signal participation*, participants identified observable indicators of active engagement. They shared observations of both physical and more subtle signs, such as a patient's gaze or posture, as well as their level of engagement and initiative. Indicators included patients expressing a desire to try tasks themselves, being active, taking responsibility, showing interest, setting relevant goals, and working towards them. Asking questions is also regarded as a sign of participation. On a more diffuse level, some participants mentioned having an intuitive sense of active or lacking participation, experienced as a gut feeling during patient interactions. As one participant described:

> I think you notice very clearly when people don't feel involved, then I think you sense that something is off." (P5)

Participants described their role in *facilitating participation.* They expressed that this involves listening attentively, having the patience to summarise, confirm and guide, as well as to inspire and encouraging activity and to assist in formulating goals and objectives.

> … to shed light on their problems. What would you like to have help with? Then it can be not just a hearing aid, but something that comes later, a thought or something. (P5)

Another way participants facilitate participation is through open communication with the patient, for example in situations where hearing thresholds do not indicate hearing loss, yet the patient experiences difficulties. One participant shared that they would explain to the patient that hearing aids may not be beneficial, but that the patient is welcome to try them. This makes patients feel involved and included in the decision process. In contrast, there are times when the *patient is not included in certain decisions*. In the same example as above, another participant revealed that they would make the decision on behalf of the patient and choose not to offer hearing aids at that point. There are also other clinical decisions where participants do not necessarily encourage patient involvement. They elaborated on decisions that are more difficult to foster patient participation in, for example, the selection of the test battery (i.e. the set of audiological tests conducted during assessment) or the specific brand or model of hearing aids. Another situation that does not invite participation is when regulations must be followed, such as determining who is entitled to compensation (e.g. financial or service-related support within the healthcare system).

Participants discussed the *over-engagement seen in some patients*, sharing that patient involvement can sometimes lead to unwanted consequences. These include an excessive focus on one's hearing loss and hearing aids, rather than viewing hearing loss and its consequences holistically as a part of one's life. Some participants noticed that overly analytical engagement and heightened attention to hearing loss may cause patients to focus more on theoretical discussions than on adjusting to the practical, day-to-day reality of living with hearing loss. Participants also described situations where high engagement could become counterproductive:

> … [the patient] had read about [hearing aid] directivity and real insertion gain measurements and all that on the internet, and had brought literature

> and he said, we can do this and this, and this, and that. And it was perhaps a bit too much, because it rather harmed than helped, sort of. It all turned out so that it became theoretical discussions instead of hearing rehabilitation, almost. (P11)

Self-efficacy

Self-efficacy encompasses the belief in one's own ability to successfully manage a given situation. In the subtheme *reflecting on self-efficacy*, some participants reported that they consistently consider patients' self-efficacy during visits, while others focus on it more specifically in relation to the care and handling of hearing aids. One participant observed that self-efficacy is often lower in patients whose hearing is so poor that they struggle to follow ordinary conversations. Participants described this particularly in relation to patients with more severe hearing loss.

> It is sometimes very clear that there are many people who have very low self-efficacy. And it's not so strange because their hearing is so bad that they have difficulty hearing ordinary conversations. (P4)

The participants mentioned that they observe different *signs of self-efficacy* in different patients. These may include signals such as being open and clear about their hearing loss and challenges to those around them, handling their hearing aids with confidence, and demonstrating skills in maintaining them. Participants also shared that some patients demonstrate high self-efficacy through their willingness to make decisions and express confidence in their abilities.

> It's when they say they can handle it: yes, I'll get this, there are no difficulties. (P15)

In the subtheme *strengthening self-efficacy*, participants elaborated on how they think about and work towards increasing patients' confidence in their own ability to manage hearing-related challenges. A variety of methods and approaches were described. One way is to help patients focus on what is positive and what is already working. Others include providing information and engaging in dialogue, offering encouragement and motivation, and supporting patients in trying things for themselves. Participants also talked about building trust and allowing sufficient time to explore patients' needs. Addressing signs of stress by acknowledging them, discussing the patient's concerns, and using calming techniques can help the patients feel that their rehabilitation is a collaborative process with the audiologist, and may ultimately contribute to increased confidence.

> Do you feel stressed? Then they usually admit it, sometimes they are also stressed that my time will not be enough for them, and then I usually say that I have plenty of time for you, we have a whole hour … …. There's nothing to worry about, we're going to do this together. (P12)

Control

In this context, control refers to a sense of power to influence and manage hearing-related challenges and devices. Within this theme, participants discussed different aspects of control, which they viewed as a complex concept with both positive and negative connotations. In the subtheme *ambiguity and variability of control*, participants shared that the concept may be interpreted and experienced differently depending on the individual patient. Moreover, the need for control appears to vary from person to person. Generally, it seems easier for patients to have control over their technology than over hearing situations. For instance, using apps or volume control can provide a feeling of control. Some participants reflected that considering control within their clinical practice is a relatively new perspective, and they had not previously considered it as an immediate goal of hearing rehabilitation. They also considered that the audiologist, the patient, and society share a joint responsibility for creating conditions that enable patients to experience a sense of control. Finally, some participants questioned the extent to which control is achievable:

> It's not the case that when you have a hearing loss, you're ever cured. It is something chronic. So I don't know if you ever really have control over your hearing situation. (P12)

The audiologists discussed the various *signs of control* when patients indicate whether they feel in control or not. Participants shared that they observe signs of control in patients who begin to hear better in situations that were previously described as difficult, who are able to participate in social contexts, who no longer need to ask others to repeat themselves, and who ask questions and show initiative during clinical visits. Conversely, they expressed interpreting signs of a loss of control when patients appear stressed when talking about their hearing, or when they express that they are not visiting the audiologist of their own initiative.

> I have probably met patients who have no control because sometimes they wonder what they are doing in my office. I have received a referral to discuss

> having hearing aids, I don't want them, it was the doctor who sent it, I don't want to come here. (P15)

In *framing when discussing control* some participants reflected that they tend to frame it in terms of being safe or secure, such as when patients experience a sense of security or safety in using their hearing aids. Others reported that they do not talk to patients explicitly about control. Instead, they discuss hearing aid management more generally to assess whether patients appear to have control over the technology. Another subset of participants shared that they only address control with specific patient groups, such as first-time users with more severe hearing loss.

> To talk about it, it's very, very rare when it comes to regular hearing aid users… … If so, [I talk with] first-time users who have a more severe hearing loss. (P19)

Clear information delivery plays a key role in enhancing perceived control through clarity and empathy. This includes outlining all available options and opportunities for patients and making it as easy as possible for them to make informed choices. Participants shared that they aim to increase feelings of control by encouraging patients to express their thoughts and experiences. Some participants also described the importance of listening calmly and attentively when patients describe feeling out of control. Furthermore, participants highlighted the value of communicating to patients that it is not always possible to have control, an insight that may itself help increase the patients' feeling of control.

> You inform about what you can do then perhaps to feel that you have more control, but also that you sometimes talk about, for example, that it may not be possible to have control in all situations. (P13)

Discussion

This study aimed to explore how audiologists act in their clinical practice in relation to five dimensions of empowerment on the hearing health journey: knowledge, skills and strategies, participation, self-efficacy, and control. These dimensions were previously identified in a study on patient empowerment on the hearing health journey (Gotowiec et al. 2022), and the current study showed that audiologists viewed all five empowerment dimensions as relevant to both their patients and their own clinical work. Overall, the results indicate that audiologists most actively and consistently engage with the empowerment dimensions related to knowledge, and skills and strategies. In contrast, the psychological dimensions, particularly self-efficacy and control, receive comparatively less systematic attention and appear less embedded in routine clinical practice. Although previous research suggests that empowerment is an important aspect of the patient-audiologist dyad (European Patients' Forum 2017), there is a noted lack of research on this dyad, in particular deep explorations of how it manifests in patient-centered care (Grenness et al. 2014). To our knowledge, this is the first qualitative study to investigate both the observable (knowledge delivery, skill and strategy teaching, encouraging participatory visits) and more implicit (building self-efficacy and bolstering control) aspects of clinical care. The findings from this study both confirm and extend prior literature in this field.

Information and knowledge delivery was highlighted as a central aspect of hearing rehabilitation and described as a multifaceted topic. Many participants framed themselves as distributors of information who need to meet each patient at their level of existing knowledge, and then customise the amount of information delivered, and tailor the most suitable method of communication for the individual. This mirrors a previous study that found that audiologists were acutely aware of the importance of providing the correct type and amount of information and how information delivery had the potential to empower patients (Laplante-Lévesque et al. 2013). The importance in particular of having written information readily available and repeating information was also emphasised in the current study, confirming prior research demonstrating that audiologists who repeat information and provide information in written form were appreciated by patients (Laplante-Lévesque et al. 2013), and could even influence the intention of a patient to use hearing devices (Meister, Grugel, and Meis 2014). Overall, the findings in this domain support the notion that the receipt of information and knowledge is a central aspect of the empowerment process (Aujoulat, d'Hoore, and Deccache 2007), and that audiologists play a role in the feeling of empowerment related to knowing about hearing loss, hearing rehabilitation, and solution possibilities (Barker, Leighton, and Ferguson 2017; Laplante-Lévesque et al. 2013).

Prior work suggests that many patients gain strategies before their first clinical visit, by observing others, or by unconsciously developing strategies to cope with hearing-related communication challenges (Gotowiec et al. 2022; Wänström et al. 2014). The current study shows that audiologists perceive that

they, too, have a prominent and varied role in facilitating skill and strategy acquisition and state the importance of assessing the existing level of skill and strategy knowledge and use when they meet a patient. This finding supports previous research suggesting that not only do audiologists support skill and strategy development, but that this aspect of hearing rehabilitation can also promote empowerment (Bennett et al. 2021; Gotowiec et al. 2022).

The findings within the participation dimension both align with and diverge from previous research. Participants reported an intention to support patient participation by observing indicators of engagement and promoting involvement through open communication, the use of decision aids, and the encouragement of shared-decision-making throughout the hearing rehabilitation process. The benefits of this approach are supported by prior literature suggesting that using these techniques can have the dual effect of both fostering participation and bolstering empowerment (Bennett et al. 2021; Poost-Foroosh et al. 2011; Pryce et al. 2016).

The deliberate decision not to include patients in the decision-making process, as described by some participants, does not necessarily have to be disempowering. Research has shown that patients may feel satisfied with not being involved in decision-making if they perceive audiologists as knowledgeable experts (Gotowiec et al. 2022). This assumes that clinicians cultivate a relationship of trust, assuring patients that their decisions are grounded in professional competence and informed by evidence-based practice. The overall finding in this dimension, that participants prioritise and consider participation as an integral part of the rehabilitation process, stands in contrast to previous literature suggesting that audiologists rarely use techniques that foster shared decision-making or collaborative problem solving (Barker, Leighton, and Ferguson 2017). It may be that the participant population included in this study were particularly focused on empowering patients through patient-centered care, where the patient is actively encouraged to work in partnership with their audiologist to develop a plan customised to their unique needs (Bennett et al. 2021).

Both the current work and prior research show that self-efficacy is an important, somewhat implicit, part of hearing rehabilitation. Increased self-efficacy has been linked to more successful uptake of hearing aids and better rehabilitation outcomes (Ferguson, Woolley, and Munro 2016; Hickson et al. 2014). In turn, these improved rehabilitation outcomes can lead to feelings of empowerment (Convery et al. 2016). The self-efficacy dimension in the current study focused on how participants viewed this topic in relation to their patients and rehabilitation delivery. In the future, it would be valuable to explore how audiologists experience self-efficacy in their own work, as prior findings indicate that audiologists do not always feel confident in their professional practices (Laplante-Lévesque et al. 2012).

Much like prior work on patient empowerment in hearing rehabilitation (Gotowiec et al. 2022), the current findings reveal that control is not as central to this process as it may be in other chronic illnesses (Zimmerman 1995). Nonetheless, control is present as a dimension of hearing rehabilitation that can manifest first as a loss of control over hearing-related aspects of an individual's life (Carson 2005). Previous work demonstrates that using hearing aids (Gotowiec et al. 2022), and hearing-related smartphone apps (Maidment, Ali, and Ferguson 2019) may help patients acquire a sense of control over their hearing challenges, and the audiologist is a central actor in delivering these tools to the patient. Furthermore, based on the current findings, it is possible that audiologists' main roles in enhancing a sense of control may be to focus on information delivery, strategy teaching, and clear communication, which then carries over to boost the patient's feeling of control. A future intervention study could focus on building knowledge and strategies as a method to boost control and, in turn, feeling of empowerment.

In this study, self-efficacy and control appeared less explicitly integrated into everyday rehabilitation compared to knowledge and skills/strategies. Several factors may help explain this pattern. Ekberg, Grenness, and Hickson (2014) studied a corpus of 63 initial audiologist-patient conversations. They observed that audiology appointments are strongly structured around testing, device-focused tasks, and hearing loss-based decisions, leaving less room for broader psychosocial discussion. They also found that when psychosocial or emotional concerns were raised, these were not followed up and the conversation was redirected towards technical matters (Ekberg, Grenness, and Hickson 2014). In another study, audiologists reported limited training and confidence in providing emotional support, (Bennett et al. 2021) which can create uncertainty about how to respond to psychological aspects of patients' experiences. There are also data showing that clinicians may be unsure how to act on psychosocial information, including when or where to refer patients for additional support

(Bennett et al. 2020). Although this evidence does not target self-efficacy and control specifically, it points to broader challenges in integrating psychological dimensions into routine clinical practice, which may help explain why these aspects were addressed less directly by participants in the current study. Taken together, these findings suggest that the less explicit focus on self-efficacy and control may reflect a combination of structural constraints in clinical encounters, limited training in addressing psychological aspects, and the more abstract nature of these dimensions, which may make them harder to address in routine practice.

The assumption underlying this work is that supporting patients in acquiring knowledge, skills, and strategies, and increasing participation, self-efficacy, and control, and ultimately feeling more empowered, is a desirable goal for audiologists. The general sentiment showcased by these findings supports this assumption. However, it may be that in certain contexts, patients do not want to feel empowered in these specific ways. For example, a patient may not want to participate in decision making in some circumstances but be highly involved in other choices. They may opt not to go forward with hearing aids, after discussing all the options with their audiologist. For this reason, framing empowerment as being complementary to patient-centered care is an important aspect of this work. The goal of empowering patients is to adjust the traditional "top-down" model of healthcare and put the patient at the centre of their hearing rehabilitation. In multiple contexts, the participants in this study brought up the importance of meeting patients where they are and assessing their existing level knowledge and strategy use, and feelings of confidence and control. This aligns with literature suggesting that patient-centered care in the realm of empowerment is built on the need for clinicians to be active listeners (Laplante-Lévesque et al. 2013; Manchaiah et al. 2019). Therefore, the patient-audiologist dyad can be considered as a key component of patient empowerment.

Clinical implications

The findings suggest that audiologists may need to work more explicitly with the psychological dimensions of empowerment, particularly self-efficacy and control, alongside knowledge, and skills and strategies. In practice, this could mean briefly exploring patients' confidence in managing hearing situations and their sense of control in everyday communication.

Simple prompts or short check-ins during consultations may help bring these aspects into routine care without adding substantial time. The results also point to a need for increased support and training in addressing psychosocial aspects of hearing rehabilitation. At the same time, a person-centered approach remains essential, as patients differ in how and to what extent they want to engage in different aspects of empowerment.

Methodological considerations

A methodological consideration in this study was how we approached trustworthiness, which is one way of assessing scientific rigour in qualitative research. The sample size was considered sufficient in relation to the concept of information power, where the more relevant information participants hold for the study aim, the fewer participants are needed (Malterud, Siersma, and Guassora 2016). Given the focused study aim, the relatively specific and knowledgeable participant group, and the use of focus groups to generate rich data, the sample was considered to provide sufficient information power. Trustworthiness is built on credibility, transferability, and dependability (Guba and Lincoln 1989). In this study, credibility was enhanced through the selection of research and analytical methods most relevant to the aims at hand. Based on these aims and the goal of having participants share and compare their experiences with one another, both by agreeing and contrasting (Breen 2006), focus group methodology was determined to be the ideal design. Transferability is the degree to which findings are transferable to another context (Tobin and Begley 2004), and dependability ensures that the findings are able to be repeated. Both criteria were attended to through the thick descriptions of the research process undertaken in this work, including the theoretical underpinnings, data collection and analytical methods (Guba and Lincoln 1989). Finally, overall trustworthiness was further ensured through negative cases analysis, where data noted to be inconsistent with the theoretically- and empirically- driven empowerment dimensions were discussed and examined between JL and SG.

While the goal of this research was not representativeness, it is important to note that the topic guide was informed by an existing empowerment framework (Zimmerman 1995) and previous research on patient empowerment on the hearing health journey (Gotowiec et al. 2022). This means that the focus group discussions were framed around these *a priori*

dimensions, which in turn influenced the theme-based analyses. This reflects a theoretically informed approach, where existing frameworks and prior knowledge informed both the data collection and the analysis. The alternative to this would have been a grounded theory study open to all interpretations of empowerment, which would not have been an appropriate method to fit the aims of the current study.

The data collection for this study was conducted during the middle of the Covid-19 pandemic, which may have affected the number of participants willing to take part in an online focus group. At the time, audiologists in Sweden were experiencing an unprecedented working environment in the healthcare system, which may have influenced the number of people willing to participate in this study. It is therefore possible that the focus groups comprised participants who were more likely to be highly interested and particularly driven to share and learn about this topic. However, as the goal of the study was to explore a breadth of experiences, attitudes, and opinions (Kitzinger 1995), if a bias in recruitment did exist, it may have contributed to a wider variety of experiences and thoughts to share. Additionally, participants' contributions may have been influenced by social desirability bias, particularly as certain empowerment-related dimensions (e.g. participation and patient engagement) are generally viewed as positive in clinical practice. However, this was not consistently reflected in the data, as participants also described challenges, uncertainties, and variation in their practices. Future studies could complement self-reported with observational or triangulated methods.

Conclusions and future directions

To our knowledge, this is the first study to directly explore audiologists' experiences and opinions surrounding patient empowerment through discussions of the five dimensions of empowerment. The findings indicate that audiologists consider varied perspectives of both the explicit and implicit aspects in their practices of hearing rehabilitation. This study supports previous work that focused specifically on knowledge, skills and strategies, and participation in the realm of hearing rehabilitation and extends that work by demonstrating that facets of self-efficacy and control are also important considerations for audiologists. The insights around the empowerment dimensions have potential implications for professional focus and education. The findings could inform audiology curricula, training modules, and continuing professional development by providing clearer conceptual foundations for discussing and supporting empowerment in clinical encounters. Future research is needed that delves more deeply into how audiologists themselves feel empowered in their practice, and how that may intersect with their patients' experiences of being empowered. In addition, a structured empowerment assessment tool, grounded in empirical work, could help audiologists more consistently identify, address, and communicate about empowerment within rehabilitation.

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Author contributions

CRediT: **Josefina Larsson**: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing; **Sarah Gotowiec**: Conceptualization, Formal analysis, Investigation, Methodology, Project administration, Resources, Writing – original draft, Writing – review & editing.

Disclosure statement

No potential conflict of interest was reported by the author(s). Both authors were employed by WS Audiology at the time the study was conducted.

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References

Anderson, R. M., M. M. Funnell, P. M. Butler, M. S. Arnold, J. T. Fitzgerald, and C. C. Feste. 1995. "Patient Empowerment: Results of a Randomized Controlled Trial." *Diabetes Care* 18 (7):943–949. https://doi.org/10.2337/diacare.18.7.943.

Aujoulat, I., W. d'Hoore, and A. Deccache. 2007. "Patient Empowerment in Theory and Practice: Polysemy or Cacophony?" *Patient Education and Counseling* 66 (1): 13–20. https://doi.org/10.1016/j.pec.2006.09.008.

Barker, A. B., P. Leighton, and M. A. Ferguson. 2017. "Coping Together with Hearing Loss: A Qualitative

Meta-Synthesis of the Psychosocial Experiences of People with Hearing Loss and Their Communication Partners." *International Journal of Audiology* 56 (5):297–305. https://doi.org/10.1080/14992027.2017.1286695.

Barker, F., S. De Lusignan, and D. Cooke. 2018. "Improving Collaborative Behaviour Planning in Adult Auditory Rehabilitation: Development of the I-Plan Intervention Using the Behaviour Change Wheel." In *Annals of Behavioral Medicine*. vol. 52, 489–500. Oxford University Press. https://doi.org/10.1007/s12160-016-9843-3.

Bennett, R. J., C. Barr, J. Montano, R. H. Eikelboom, G. H. Saunders, M. Pronk, J. E. Preminger, M. Ferguson, B. Weinstein, E. Heffernan, et al. 2021. "Identifying the Approaches Used by Audiologists to Address the Psychosocial Needs of Their Adult Clients." *International Journal of Audiology* 60 (2):104–114. https://doi.org/10.1080/14992027.2020.1817995.

Bennett, R. J., C. J. Meyer, B. J. Ryan, and R. H. Eikelboom. 2020. "How Do Audiologists Respond to Emotional and Psychological Concerns Raised in the Audiology Setting?" *Ear and Hearing* 41 (6):1675–1683. https://doi.org/10.1097/AUD.0000000000000887.

Braun, V., and V. Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3 (2): 77–101. https://doi.org/10.1191/1478088706qp063oa.

Braun, V., and V. Clarke. 2012. "Thematic Analysis." In *APA Handbook of Research Methods in Psychology, Vol 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological*, 57–71. H. Cooper (Editor). pp. 57–71. Washington, DC: American Psychological Association.

Breen, R. L. 2006. "A Practical Guide to Focus-Group Research." *Journal of Geography in Higher Education* 30 (3):463–475. https://doi.org/10.1080/03098260600927575.

Carson, A. J. 2005. "What Brings You Here Today?" The Role of Self-Assessment in Help-Seeking for Age-Related Hearing Loss." *Journal of Aging Studies* 19 (2):185–200. https://doi.org/10.1016/j.jaging.2004.07.001.

Cash, P., and C. Snider. 2014. "Investigating Design: A Comparison of Manifest and Latent Approaches." *Design Studies* 35 (5):441–472. https://doi.org/10.1016/j.destud.2014.02.005.

Cerezo, P. G., M. E. Juvé-Udina, and P. Delgado-Hito. 2016. "Concepts and Measures of Patient Empowerment: A Comprehensive Review." *Revista Da Escola De Enfermagem Da U S P* 50 (4):667–674. https://doi.org/10.1590/s0080-623420160000500018.

Convery, E., G. Keidser, L. Hickson, and C. Meyer. 2016. "Beyond Hearing Loss: Self-Management in Audiological Practice." *The Hearing Journal* 69 (3):22–24.

Cox, R. M., G. C. Alexander, and G. A. Gray. 2005. "Who Wants a Hearing Aid? Personality Profiles of Hearing Aid Seekers [Research Support, U.S. Gov't, Non-P.H.S]." *Ear and Hearing* 26 (1):12–26. http://www.ncbi.nlm.nih.gov/pubmed/15692301. https://doi.org/10.1097/00003446-200502000-00002.

Creswell, J. W., and C. N. Poth. 2017. *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*. London: Sage Publications.

Dos Santos Marques, I. C., L. M. Theiss, C. Y. Johnson, E. McLin, B. A. Ruf, S. M. Vickers, M. N. Fouad, I. C. Scarinci, and D. I. Chu. 2021. "Implementation of Virtual Focus Groups for Qualitative Data Collection in a Global Pandemic." *American Journal of Surgery* 221 (5):918–922. https://doi.org/10.1016/j.amjsurg.2020.10.009.

Ekberg, K., C. Grenness, and L. Hickson. 2014. "Addressing Patients' Psychosocial Concerns Regarding Hearing Aids Within Audiology Appointments for Older Adults." *American Journal of Audiology* 23 (3):337–350. https://doi.org/10.1044/2014_AJA-14-0011.

European Patients' Forum. 2017. Toolkit for Patient Organisations on Patient Empowerment. Belgium: EPF.

Ferguson, M. A., J. Gavrilis, J. Larsson, R. J. Bennett, P. Incerti, and G. Engelund. 2026. "Understanding the Correlates of Empowerment in a Clinical Hearing Loss Population" *International Journal of Audiology*:1–12. https://doi.org/10.1080/14992027.2026.2619591.

Ferguson, M. A., A. Woolley, and K. J. Munro. 2016. "The Impact of Self-Efficacy, Expectations, and Readiness on Hearing Aid Outcomes." *International Journal of Audiology* 55 (suppl 3):S34–S41. https://doi.org/10.1080/14992027.2016.1177214.

Garstecki, D. C., and S. F. Erler. 1998. "Hearing Loss, Control, and Demographic Factors Influencing Hearing Aid Use Among Older Adults." *Journal of Speech, Language, and Hearing Research* 41 (3):527–537. https://doi.org/10.1044/jslhr.4103.527.

Gomez, R., A. Habib, D. W. Maidment, and M. A. Ferguson. 2022. "Smartphone-Connected Hearing Aids Enable and Empower Self-Management of Hearing Loss: A Qualitative Interview Study Underpinned by the Behavior Change Wheel." *Ear and Hearing* 43 (3):921–932. https://doi.org/10.1097/aud.0000000000001143.

Gotowiec, S., J. Larsson, P. Incerti, T. Young, K. Smeds, F. Wolters, P. Herrlin, and M. Ferguson. 2022. "Understanding Patient Empowerment Along the Hearing Health Journey." *International Journal of Audiology* 61 (2):148–158. https://doi.org/10.1080/14992027.2021.1915509.

Green, J., and N. Thorogood. 2018. *Qualitative Methods for Health Research* (J. Seaman, Ed. 4th ed.). London: SAGE Publications.

Grenness, C., L. Hickson, A. Laplante-Lévesque, and B. Davidson. 2014. "Patient-Centred Audiological Rehabilitation: Perspectives of Older Adults Who Own Hearing Aids." *International Journal of Audiology* 53 (suppl 1):S68–S75. https://doi.org/10.3109/14992027.2013.866280.

Guba, E. G., and Y. S. Lincoln. 1989. *Fourth Generation Evaluation*. London: Sage.

Hickson, L., C. Meyer, K. Lovelock, M. Lampert, and A. Khan. 2014. "Factors Associated with Success with Hearing Aids in Older Adults." *International Journal of Audiology* 53 (suppl 1):S18–S27. https://doi.org/10.3109/14992027.2013.860488.

Kitzinger, J. 1995. "Qualitative Research. Introducing Focus Groups." *BMJ* 311 (7000):299–302. https://doi.org/10.1136/bmj.311.7000.299.

Knudsen, L. V., A. Laplante-Lévesque, L. Jones, J. E. Preminger, C. Nielsen, T. Lunner, L. Hickson, G. Naylor, and S. E. Kramer. 2012. "Conducting Qualitative Research in Audiology: A Tutorial." *International Journal*

of Audiology 51 (2):83–92. https://doi.org/10.3109/14992027.2011.606283.

Knudsen, L. V., C. Nielsen, S. E. Kramer, L. Jones, and A. Laplante-Lévesque. 2013. "Client Labor: Adults with Hearing Impairment Describing Their Participation in Their Hearing Help-Seeking and Rehabilitation." *Journal of the American Academy of Audiology* 24 (3):192–204. https://doi.org/10.3766/jaaa.24.3.5.

Laplante-Lévesque, A., L. D. Jensen, P. Dawes, and C. Nielsen. 2013. "Optimal Hearing Aid Use: Focus Groups With Hearing Aid Clients and Audiologists." *Ear and Hearing* 34 (2):193–202. https://doi.org/10.1097/AUD.0b013e31826a8ecd.

Laplante-Lévesque, A., L. V. Knudsen, J. E. Preminger, L. Jones, C. Nielsen, M. Öberg, T. Lunner, L. Hickson, G. Naylor, and S. E. Kramer. 2012. "Hearing Help-Seeking and Rehabilitation: Perspectives of Adults with Hearing Impairment." *International Journal of Audiology* 51 (2):93–102. https://doi.org/10.3109/14992027.2011.606284.

Maidment, D. W., Y. H. K. Ali, and M. A. Ferguson. 2019. "Applying the COM-B Model to Assess the Usability of Smartphone-Connected Listening Devices in Adults with Hearing Loss." *Journal of the American Academy of Audiology* 30 (5):417–430. https://doi.org/10.3766/jaaa.18061.

Malterud, K., V. D. Siersma, and A. D. Guassora. 2016. "Sample Size in Qualitative Interview Studies: Guided by Information Power." *Qualitative Health Research* 26 (13):1753–1760. https://doi.org/10.1177/1049732315617444.

Manchaiah, V., M. L. Bellon-Harn, A. L. Dockens, J. H. Azios, and W. E. Harn. 2019. "Communication between Audiologist, Patient, and Patient's Family Members during Initial Audiology Consultation and Rehabilitation Planning Sessions: A Descriptive Review." *Journal of the American Academy of Audiology* 30 (9):810–819. https://doi.org/10.3766/jaaa.18032.

McAllister, M., G. Dunn, K. Payne, L. Davies, and C. Todd. 2012. "Patient Empowerment: The Need to Consider It as a Measurable Patient-Reported Outcome for Chronic Conditions." *BMC Health Services Research* 12 (1):157. https://doi.org/10.1186/1472-6963-12-157.

Meister, H., L. Grugel, and M. Meis. 2014. "Intention to Use Hearing Aids: A Survey Based on the Theory of Planned Behavior." *Patient Preference and Adherence* 8:1265–1275. https://doi.org/10.2147/PPA.S65008.

O'Brien, B. C., I. B. Harris, T. J. Beckman, D. A. Reed, and D. A. Cook. 2014. "Standards for Reporting Qualitative Research: A Synthesis of Recommendations." *Academic Medicine* 89 (9):1245–1251. https://doi.org/10.1097/acm.0000000000000388.

Patton, M. Q. 2002. *Qualitative Research and Evaluation Methods*. 3rd ed. London: SAGE Publications.

Polit, D. F., and C. T. Beck. 2017. *Nursing Research: Generating and Assessing Evidence for Nursing Practice* 11th ed., Philadelphia, PA: Wolters Kluwer.

Poost-Foroosh, L., M. B. Jennings, L. Shaw, C. N. Meston, and M. F. Cheesman. 2011. "Factors in Client–Clinician Interaction that Influence Hearing Aid Adoption." *Trends in Amplification* 15 (3):127–139. https://doi.org/10.1177/1084713811430217.

Pryce, H., A. Hall, A. Laplante-Lévesque, and E. Clark. 2016. "A Qualitative Investigation of Decision Making During Help-Seeking for Adult Hearing Loss." *International Journal of Audiology* 55 (11):658–665. https://doi.org/10.1080/14992027.2016.1202455.

QSR International. 2020. *NVivo*. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Stepanian, N., M. H. Larsen, J. B. Mendelsohn, K. L. Mariussen, and K. Heggdal. 2023. "Empowerment Interventions Designed for Persons Living with Chronic Disease - A Systematic Review and Meta-Analysis of the Components and Efficacy of Format on Patient-Reported Outcomes." *BMC Health Services Research* 23 (1):911. https://doi.org/10.1186/s12913-023-09895-6.

Tobin, G. A., and C. M. Begley. 2004. "Methodological Rigour Within a Qualitative Framework." *Journal of Advanced Nursing* 48 (4):388–396. https://doi.org/10.1111/j.1365-2648.2004.03207.x.

World Health Organization. 1998. *Health Promotion Glossary (WHO/HPR/HEP/98.1)*. Geneva: World Health Organization.

World Health Organization 2004. The Global Burden of Disease. Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/43942/9789241563710_eng.pdf

Wänström, G., M. Öberg, E. Rydberg, T. Lunner, A. Laplante-Lévesque, and G. Andersson. 2014. "The Psychological Process from Avoidance to Acceptance in Adults With Acquired Hearing Impairment." *Hearing Balance and Communication* 12 (1):27–35. https://doi.org/10.3109/21695717.2013.875243.

Zimmerman, M. A. 1995. "Psychological Empowerment: Issues and Illustrations." *American Journal of Community Psychology* 23 (5):581–599. https://doi.org/10.1007/BF02506983.