

Title: Barriers and facilitators to asking adults with hearing loss about their emotional and psychological well-being: a COM-B analysis

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Barriers and facilitators to asking adults with hearing loss about their emotional and psychological well-being: a COM-B analysis

Abstract

Objective: To explore the barriers and facilitators faced by hearing healthcare clinicians (HHCs) with respect to asking adults with hearing loss (HL) about their emotional well-being.

Design: This qualitative study was conducted using semi-structured individual interviews and focus groups. The interview topic guide was developed based on the COM-B model.

Study sample: Fifteen HHCs of a single hearing services organisation in Western Australia across 13 clinic locations participated.

Results: Barriers and facilitators that may influence HHCs' behavior of routinely asking adults about their emotional well-being include having the knowledge and skills to ask about emotional well-being, forgetting to ask, awareness of the emotional impacts of HL, time and tools for asking, clients' reactions to being asked, supportive peers, normalisation of discussions relating to emotional well-being, presence of significant others, emotions associated with asking, being in the habit of asking, reminders, beliefs about consequences and confidence or capabilities, and scope of audiology practice.

Conclusions: Application of the COM-B model identified barriers in capabilities (e.g., knowledge), opportunities (e.g., tools), and motivation (e.g., beliefs about benefits of asking about emotions) that need to be addressed for HHCs to ask their clients about their emotional well-being.

Introduction

Hearing loss can be emotionally distressing for adults, causing feelings of frustration, embarrassment, inferiority and loneliness^{1,2}. However, individuals often do not seek help for their distress due to the social stigma associated with emotional and psychological health³⁻⁵. Adults with hearing loss may develop long-term relationships with their hearing healthcare clinicians (HHCs), to whom they may disclose their emotional experiences associated with hearing difficulties⁶. Therefore, HHCs could provide emotional support (e.g., providing information on and delivering therapeutic interventions for mental well-being) to adults with hearing loss. Yet, research shows that the majority of HHCs do not routinely provide emotional support in the audiology setting⁷⁻¹⁰. Interventional research is needed to help HHCs better address the emotional impacts of hearing loss within routine care.

While the majority of HHCs offer little emotional support^{10,11}, those who do, employ approaches such as exploration of psychosocial impacts of hearing loss, development of personalised goals, involvement of significant others in the rehabilitation program, and promotion of self-management strategies^{10,12}. In addition, HHCs may provide emotional support, incorporating emotion-focussed counselling skills, therapeutic counselling techniques, and recommendation/referral for additional support outside of the audiology setting (e.g., a psychologist)¹⁰. Emotion-focussed counselling is described by HHCs to include active listening to encourage dialogue, asking questions to further explore the emotional condition, expressing concern for clients' well-being, use of client-centred communication, expressing empathy, acknowledging and validating the clients' emotions, and making time and space for conversations about the client's emotional state¹⁰.

The majority of HHCs do not routinely provide emotional support⁷⁻¹⁰, self-reporting barriers to include feeling under-skilled, lack of training, worry that they may get out of their depth, time/caseload pressures and lack of clarity regarding their role and responsibilities⁷. A recent systematic review demonstrates similar barriers for GPs to initiate conversations with clients about emotional distress symptoms¹³. This review also demonstrates that GPs clinical behaviours for providing emotional support can be improved through addressing barriers related to GPs' skills relating to asking about, exploring, explaining, and negotiating or guiding patients towards new understandings relating to their emotional distress; and upfront provision of information to assist management of expectations about recovery and improve engagement in treatment¹³.

Given that recent research suggests that HHCs may not routinely provide emotional support to adults with hearing loss^{10, 11}, we aimed to develop an intervention to increase the emotional support provided in audiology clinics. Interventions to improve clinical services depend on changing the behaviour of the health professionals delivering the services¹⁴. The COM-B model of behaviour change recognises that barriers and facilitators of behaviour change may relate to Capability (i.e., strengths, skills, and knowledge for performing a behaviour), Opportunity (i.e., accessible and acceptable social and physical environment for the behaviour to occur), or Motivation (i.e., reflective and automatic motivations to do the behaviour) (see Supplementary Figure 1). The COM-B model proposes that if a behaviour is not taking place, barriers in one or more of these areas need to be addressed. The COM-B model is widely used in the healthcare setting¹⁵⁻¹⁷, including in audiology research¹⁸⁻²⁰.

In the previous phase of the broader project, we explored potential opportunities for developing a behavioural intervention aimed at improving emotional support²¹. Participants (HHCs, clinic receptionists and managers, adults with hearing loss and their significant others) identified three behaviours to be the most promising within the audiology setting, including the HHCs (1) asking about, (2) providing information on, and (3) delivering therapeutic intervention for emotional well-being. In the previous phase, participating adults with hearing loss and significant others specifically expressed a desire for HHCs to step into the role of counsellor and directly ask clients about how their hearing loss is impacting their emotional well-being. They emphasised that increasing the frequency with which HHCs ask about their emotional well-being would increase the likelihood that clients would receive timely and appropriate treatment²¹. Literature also suggests that skills related to asking about mental health could be a factor influencing GPs' communication about emotional concerns¹³, and there is a relationship between the ability to detect emotional disorders and the ability to give information and advice about treatment options²². However, no study explored factors influencing HHCs for asking about the emotional well-being of adults with hearing loss.

This study, therefore, aimed to use the COM-B model to explore the barriers and facilitators faced by HHCs for routinely asking adults with hearing loss about their emotional well-being (promising behaviour 1 identified within the previous study²¹). The outputs of this qualitative study will inform the development of an intervention to improve how HHCs provide emotional support within audiology consultations, including *asking* about emotional well-being.

Materials and Methods

This qualitative study was guided by the COM-B model for behaviour change¹⁴ (see Supplementary Topic Guide) and conducted using semi-structured individual interviews and focus groups with HHCs.

Participants

All participants were recruited through a single hearing services organisation in Western Australia across 13 clinic locations. The HHCs met the inclusion criteria to participate in this study if they were at least 18 years of age, able to communicate verbally, and could speak fluent English. In total, 15 HHCs (13 females and 2 males) participated, ranging in age from 25 to 53 years (mean 35.2, SD 10.0). Participants had between 2 and 25 years of clinical experience (mean 9.3, SD 7.6).

Procedure

Approval for this study was granted by the Human Research Ethics Office of The University of Western Australia (RA/4/20/5873). All HHCs employed by the partner clinic were invited to participate via email, provided with an information sheet and consent form, and presented with different time options in May 2020. All interviews were conducted by the last author (R.J.B.), a white woman born in Australia. At the time of the study, R.J.B. had extensive clinical audiology experience and was working as a postdoctoral researcher, with a focus on the social and emotional impacts of hearing loss. R.J.B. completed a Graduate Diploma in Counselling in 2011 and approached the research with the assumption that HHCs have the capacity to provide psychosocial support to their adult clients. As the interviews were conducted during the 2020 COVID-19 pandemic, the sessions were conducted remotely via Microsoft Teams, which HHCs were familiar with, to facilitate physical distancing. Eight interview sessions were conducted; six were conducted one-on-one, two of them with a group of two, and one with a group of five. Each participant attended only one session. The session with the group of five lasted for 1.5 hours, and all other sessions lasted one hour, except for one interview that took 30 minutes. All sessions were audio- and video-recorded. We reflected after each of the interviews and refined the topic guide where necessary. Data collection continued until no new data emerged from the interviews and data saturation was achieved.

Data analysis

Audio recordings were transcribed by a professional service (with identifying information removed), de-identified, and entered into Microsoft Excel for analysis. Framework analysis²³ was used to deductively analyse the transcripts using a matrix to reduce and explain the data.

The matrix developed for this study included the three main domains of the COM-B model and their sub-domains (Capability: Physical and Psychological; Opportunity: Social and Physical; and Motivation: Reflexive and Automatic). Three members of the research team conducted the analysis together to optimise rigour and trustworthiness. In Round 1, two members of the research team (R.J.B. & M.N.) independently coded the raw transcript excerpts, identifying text that represented (i) barriers to routinely asking clients about emotional well-being, or (ii) facilitators to routinely asking clients about their emotional well-being, and also coding these excerpts as to whether they represented Capability, Opportunity, or Motivation domains²⁴. In cases where the coders were unsure of the categorisation, text was highlighted but not categorised, and flagged for discussion with the third coder. Independent coding was cross-checked with discrepancies discussed to achieve resolution between the two coders and a third member of the team (C.J.M.). Then with the purpose of developing inductive categories, subthemes, and themes, identified codes were reviewed and clustered to form inductive categories within the subdomains of the COM-B. This step drew from thematic analysis methodology described by Braun and Clarke²⁵.

Results

In response to the initial interview question: “How do you currently ask your clients about the impact of their hearing loss on their emotional well-being?” only a couple of HHCs described directly asking clients about their emotional well-being, and most HHCs described some form of exploration regarding clients’ emotional well-being (e.g., only asking when the client first raised it as a concern). HHCs speculated that between 20 to 50% of clients raise emotional concerns during clinical encounters, and that they thus only ask about emotional well-being in 20-50% of cases. However, HHCs agreed that the percentage of clients who experienced reduced emotional well-being on account of their hearing loss was closer to 95-100%. A few participants speculated that between 60-80% of their clients experience ongoing emotional distress even after hearing rehabilitation.

Barriers and facilitators to routinely asking adult clients about their emotional and psychological well-being were identified within five of the COM-B domains, with the exception being physical capability (i.e., the physical strength of asking). The results from each of these five COM-B domains are discussed in more detail below, with example quotes that were representative of the barrier or facilitator. Themes and subthemes within the subdomains of the COM-B are presented in Tables 1-3 and related example quotes in Supplementary Tables 1-3.

Psychological capability

Psychological capability refers to the knowledge or psychological skills, strength or stamina to engage in the necessary mental processes for asking about emotional well-being. HHCs in this study showed a high level of *understanding/knowledge* of when and why discussions relating to emotional well-being are pertinent to the audiological setting. Participants also demonstrated an *awareness* of the various emotional impacts associated with hearing loss, with all HHCs describing first-hand experiences of working with clients who present with emotional distress in the clinical setting. However, most HHCs described a lack of knowledge and skill regarding how to directly ask about emotional well-being; specifically, they reported a knowledge gap with respect to the use of appropriate language when enquiring about emotional well-being, how to appropriately describe symptoms, and phrases to signify empathy and understanding.

“I don’t have the skills or the knowledge on how to delve into that a bit deeper.”

(Clinician 6)

A key barrier to asking about emotional well-being was a lack of knowledge and skill regarding the “*next steps*”, that is, what to do when clients respond by describing their emotional distress.

“I’m not going to ask them about it [emotional well-being], if I can’t measure it to show them that they are a right, and especially not if I can’t then fix it for them.” (Clinician 7)

Equally, those HHCs who described a greater frequency and comfort with asking about emotional well-being described this as being facilitated by knowing how to have these conversations, and how to support clients who present with distress. The barrier of *forgetting* to ask clients about their emotional well-being during consultations was mentioned by two HHCs (see Table 1 and Supplementary Table 1).

< Table 1 >

Physical Opportunity

Physical opportunity is the opportunity afforded by the environment, encompassing location, time, and resources for asking about emotional well-being¹⁴. *Time* was mentioned by most HHCs in this study, yet they tended to describe time as a modifiable factor (see Table 2 and Supplementary Table 2). Although some HHCs indicated that they do not have time in their current appointment structure for lengthy discussions about emotional well-being, most

HHCs indicated that they were able to manage their time accordingly, and it was not an impenetrable barrier but more of an inconvenience.

Few HHCs specifically described a lack of *tools* or clinical resources as a barrier to asking clients about emotional well-being. However, most HHCs described various clinical tools that they would like to see developed for their clinic that they believe would help them more frequently and more successfully ask their clients about the emotional impacts of hearing loss (see below section on solutions).

“If someone’s going to bring up a concern within an appointment, you want to have tools to be able to address that effectively.” (Clinician 8)

Social Opportunity

Social opportunity is the opportunity afforded by interpersonal influences, cultural norms or social cues that influence the way we think about asking about emotional well-being from clients. The most described phenomenon in this study was the concept of *social influence from clients*, that is, whether the HHCs’ interactions with their clients supported, or hindered, the opportunity to ask about emotional well-being. The HHCs described this phenomenon as being both a barrier and a facilitator depending on the individual client, that is, where some clients are open to and respond favourably to discussion relating to emotional well-being, others do not (see Table 2). Some HHCs described the phenomenon of social opportunity to be related to the client’s age, gender, or duration of hearing loss (NB. hearing implant clients generally have a long experience with hearing loss compared to hearing aid users).

An additional facilitator encouraging HHCs to ask about emotional well-being included the acknowledgement that asking about emotional well-being is easier when *significant others* are present.

“Sometimes, too, it’s a lot easier if you’ve got family members that come in because you’ll sometimes see the dynamics between family members for good or bad.” (Clinician 5)

Facilitators improving the opportunity for HHCs to ask about emotional well-being included access to *supportive peers*, specifically mentors to provide assistance for difficult cases, and the recent *normalisation of discussions* relating to emotional well-being due to the COVID-19 pandemic. HHCs described a shift in perception, where clients previously seemed potentially offended when asked about emotional well-being (perceived by HHCs as likely due to the stigma associated with mental health), more recently clients appeared open to discussions relating to emotional well-being (perceived by HHCs as likely due to recent

media raising awareness for the need of emotional self-care during the COVID-19 pandemic).

“I think social isolation’s become a big buzz word with COVID-19, which is... I find it quite good because now when I talk about it, it’s not taboo anymore.” (Clinician 4)

<Table 2>

Automatic Motivation

Automatic motivation refers to automatic processes involving desires (wants and needs), emotional reactions, impulses, inhibitions and reflex responses associated with asking about emotional well-being. There was variation across the interviews in terms of the *emotions associated with asking* and the extent to which the HHCs felt comfortable asking clients about their emotional well-being. Where some clients described emotional discomfort and awkwardness, others described feeling very comfortable.

“As I said, sometimes I feel quite comfortable with it.” (Clinician 1)

A few HHCs described a lack of *habit* as a barrier to asking about emotional well-being. This phenomenon was also heavily reflected in participants’ descriptions of what they felt would help them to improve the frequency with which they ask about emotional well-being; specifically, HHCs described a desire for *reminders* and prompts within the workflow. One HHC described how they use an existing item in the case history form to prompt them to ask about emotional well-being (see Supplementary Table 3).

Reflective Motivation

Reflective motivation refers to reflective processes involving plans (self-conscious intentions) and evaluations (beliefs about what is good and bad) for asking clients about their emotional well-being. When prompted about their *beliefs regarding the potential consequences* relating to asking clients about emotional well-being, most HHCs in this study described positive belief structures describing how clients would benefit from increased acknowledgement of how their hearing loss has impacted their emotional well-being.

“I think the advantages would be the fact that you’re uncovering some of these issues that, maybe, otherwise would never have been addressed. Then you can help them and get it addressed.” (Clinician 2)

A few HHCs, however, did not believe in *effectiveness of referrals*.

“Because my feeling is, even if they go to a psychologist, we don’t usually hear back. And perhaps for some of these people, especially if they’ve got a lot of hearing loss,

teamwork's needed. Because we understand the communication problems. They understand methods of dealing with anxiety, depression, or the things that can result." (Clinician 5)

There was variation across the interviews in terms of *beliefs about capabilities and confidence* asking about emotional well-being. Some HHCs believed that they lacked the confidence to ask about emotional well-being. Others perceived that they were sufficiently confident to ask about emotional well-being, whereas they often noted that they lacked the confidence to appropriately respond and/or provide emotional support when clients disclose emotional distress (see Table 3 and Supplementary Table 3).

A HHC also believed that a client who is *experiencing a life transition* may require more mental health support, specifically, young adult clients often describe increased difficulties caused by their hearing loss during a transition period, such as when starting university or a new job.

"It's their listening environment that's changed, and there's so much more work pressure on them and that's what they're actually struggling to deal with." (Clinician 14)

HHCs also expressed their *personal interest in the client as an individual* and acknowledged that asking about emotional well-being was within a HHC's *scope of practice*, most often with the caveat that the emotional distress needed to be directly linked to the hearing loss. However, there appeared to be a sense that it perhaps was not their responsibility to ask about emotional well-being.

"In rare cases, if they're not seeing anyone else, then obviously it could be quite significant, but generally, they do see their doctors and things like that. So hopefully, we're not the only person responsible for acknowledging or figuring something like that out, but obviously, for some people, there may be consequences if we're the only one they see." (Clinician 1)

One HHC described how they do not ask about emotional well-being due to concern that the emotional distress described by the client may not relate to the hearing loss.

"I know it sounds terrible, but you don't really want them to open up certain things because we're not the right people to discuss certain things with." (Clinician 5)

Some factors identified in this study had an influence on the other factors. For example, capability factors influenced motivation factors.

"I think that anxiety on the clinician's part of not quite knowing what to do [in response to psychological disclosure] and maybe creating a relationship that was outside of our scope of practice." (Clinician 8)

“I’m quite new to the game, so I think my knowledge is much less because I have less experience with it. I feel like I’m quite aware. I know a lot about it where it’s enough to know and see the impact it’s having, but still haven’t had a lot of experience, so I wouldn’t be confident in that aspect.” (Clinician 4)

<Table 3>

Solutions

HHCs expressed their desire for improved knowledge, specific tools, or environmental changes that they perceived would help them to more frequently ask about emotional well-being (see Table 4). Knowledge and skill training predominantly included example scripts, clinical guidelines, training on how to describe symptoms discussed in a GP report, and training on how to have conversations about emotional well-being. Environmental changes included prompts or reminders. Requests for resources included clinical tools to assist with identifying psychosocial goals for rehabilitation, educational videos, and client surveys.

<Table 4>

Discussion

The purpose of this qualitative study was to explore the barriers and facilitators faced by HHCs with respect to routinely asking adults with hearing loss about their emotional well-being. For the first time, this study used the COM-B model of behaviour change to explore HHCs’ perspectives on asking about emotions in audiology clinics; and the interviews and focus groups identified barriers and facilitators across five of the six COM-B domains, excluding physical capability. Overall, the findings indicated that HHCs generally believed in the benefits of asking about emotional well-being in audiology practice. However, they reported that they may sometimes not ask about emotions due to barriers associated with knowledge, available tools and time, and clients’ and HHCs’ motivations about talking about emotional well-being. These findings support previous research in other healthcare areas that showed clinicians could experience a range of barriers for exploring clients’ emotional concerns^{13, 26}.

The main barriers in psychological capability identified in this study were gaps in HHCs’ knowledge and skills regarding how to directly ask about emotions, and how to use appropriate language when enquiring about emotional well-being. HHCs also reported a lack of knowledge about approaching and guiding emotion-related conversations. Other studies on GPs indicated that this barrier could be related to the possession of communication skills²², the challenging nature of uncovering the true problems experienced by clients, or clients’

experiences of stigma regarding their emotional concerns²⁷. To overcome this barrier, the HHCs in the current study suggested practical and feasible solutions such as training sessions with example scripts and questions about how to ask clients about their emotions.

Similar to other areas of healthcare^{7, 27, 28}, time pressure for lengthy discussions about psychological well-being was a concern in this study. Whilst the majority of HHCs indicated that they were able to manage their time to cover the emotion-related questions, funding for extra time was suggested to address the time barriers to having more in-depth discussions and providing clients with emotional support.

The social influence from clients was perceived to potentially hinder discussion around emotional well-being. Clients' openness to questions about emotions was identified as a key factor that played the role of both facilitator and barrier in the context of this study. Some HHCs reported being confident in discussing emotional well-being with clients who were ready and open to talk, but not with the clients who would "*shut it down quickly.*" Given that disclosure of the symptoms of the mental health problems could be challenging^{26, 29}, some HHCs suggested sending emotion-related questions to clients before their appointment so that clients could think about the questions beforehand. In addition, the presence of significant others was identified as a facilitator to ease the conversation about emotions. The importance of significant others in audiology clinics has already been identified in other research too³⁰. Therefore, involving significant others when asking clients about emotional well-being could be an important facilitator.

The other major factors identified in this study were motivation factors. A motivation factor related to the increased hearing difficulties observed by young adult clients when they transitioned through life stages, such as starting university or employment. As starting to work could be challenging for young adults³¹, HHCs are encouraged to explore audiological and lifestyle changes when discussing mental well-being. Another important factor was beliefs about audiology scope of practice. While survey in a cross-sectional study has highlighted barriers related to Australian HHCs' beliefs about the scope of practice in addressing clients' emotional needs⁷, the qualitative interview approach used here allowed for depth of understanding; specifically some HHCs considered asking about emotional well-being as "*definitely within the scope of practice*" whilst others believed that they were not "*the right people to discuss certain things.*" Given that there is no available guideline, protocol, or specific tools for audiologists to help them with the conversation about emotional well-being, it is understandable that they might be uncertain whether asking about emotions

would be within their scope of practice; even though the HHCs in the current study expressed their beliefs about the potential advantages of uncovering emotional issues. Some HHCs also suggested a resource should be developed to structure the discussion around emotional well-being.

Clinical considerations

This study has important clinical implications for HHCs and audiology clinic managers. To improve the outcome of audiology services, an emphasis on emotionally focused communication in clinics has been suggested⁸. To facilitate asking questions about emotions, the barriers identified in the current study need to be addressed. The Behaviour Change Wheel (BCW) offers a framework for systematically developing a behaviour change intervention that will address each of these barriers¹⁴. Firstly, the knowledge gap about how to ask about emotional well-being could be reduced by training and enablement sessions as well as developing and introducing relevant tools and guidelines. Given that capability have a direct influence on motivations³², HHCs may need training, role playing, and workshops in relation to counselling skills and language to improve their abilities as well as motivation toward asking about emotions. Second, given that prompts and cues have been identified as effective techniques for changing behaviours¹⁴, introducing triggers or reminders could help HHCs to include questions about emotions in their history taking in audiology sessions.

Limitations and further research

This study increased our understanding of the current situation of discussions around emotional well-being in audiology clinics in Western Australia. However, this study had some limitations. Firstly, participants were recruited from a single chain of hearing aid clinics, limiting the applicability of the findings to other settings. Other clinics are likely to have other barriers and facilitators for routinely asking about emotional well-being. Although only a small number of HHCs participated in the study, data saturation was achieved for this sample. Second, as audiology is a profession with a relatively high proportion of females, most participants were female in this study, and it is possible that the perceived barriers and facilitators to asking patients about their emotional wellbeing would differ among male HHCs. This study aimed to understand the barriers to asking about emotional well-being within a hearing services organisation to develop a context-specific behavioural intervention to increase and enhance how these audiologists ask about emotional well-being during their clinical appointments. Future studies may explore the barriers and facilitators in other hearing services organisations to establish whether there are common barriers that perhaps need to be

addressed at a broader professional scale. Future studies are also required to develop referral pathways and to introduce how to integrate, manage, and communicate the approach of asking about emotions in clinics' routine practice.

Conclusions

For the first time, this study used the COM-B model of behaviour change to identify the barriers and facilitators to routinely asking adults with hearing loss about their emotional well-being in audiology clinics. The results identified main barriers in capabilities (e.g., knowledge), opportunities (e.g., time and tools), and motivation (e.g., beliefs about benefits of asking about emotions) that need to be addressed for audiologists to ask their clients about their emotional well-being.

Acknowledgements

The authors would like to thank the clinicians who participated in this study. This work was supported by a Raine Priming Grant from the Raine Medical Research Foundation, The University of Western Australia.

Funding

Raine Priming Grant from the Raine Medical Research Foundation, The University of Western Australia.

Conflict of Interest

The authors declare that they have no competing interests.

References

1. Vas V, Akeroyd MA, Hall DA. A data-driven synthesis of research evidence for domains of hearing loss, as reported by adults with hearing loss and their communication partners. *Trends in Hearing*. 2017;21:1-25. <https://doi.org/https://doi.org/10.1177/2331216517734088>
2. Heffernan E, Coulson NS, Henshaw H, Barry JG, Ferguson MA. Understanding the psychosocial experiences of adults with mild-moderate hearing loss: An application of Leventhal's self-regulatory model. *International Journal of Audiology*. 2016;55:S3-S12. <https://doi.org/https://doi.org/10.3109/14992027.2015.1117663>
3. Bharadwaj P, Pai MM, Suziedelyte A. Mental health stigma. *Economics Letters*. 2017;159:57-60. <https://doi.org/https://doi.org/10.1016/j.econlet.2017.06.028>
4. Salaheddin K, Mason B. Identifying barriers to mental health help-seeking among young adults in the UK: a cross-sectional survey. *British Journal of General Practice*. 2016;66:e686-e692.
5. Courtin E, Knapp M. Social isolation, loneliness and health in old age: A scoping review. *Health & Social Care in the Community*. 2017;25:799-812. <https://doi.org/https://doi.org/10.1111/hsc.12311>
6. Laird EC, Bennett RJ, Barr CM, Bryant CA. Experiences of Hearing Impairment and Audiological Rehabilitation for Older Adults with Comorbid Psychological Symptoms. *American Journal of Audiology*. 2020 29:809-824.
7. Bennett RJ, Meyer CJ, Ryan B, Barr C, Laird E, Eikelboom RH. Knowledge, beliefs and practices of Australian audiologists in addressing the psychological needs of adults with hearing loss. *The American Journal of Audiology*. 2020. https://doi.org/https://doi.org/10.1044/2019_aja-19-00087
8. Ekberg K, Grenness C, Hickson L. Addressing patients' psychosocial concerns regarding hearing aids within audiology appointments for older adults. *American Journal of Audiology*. 2014;23:337-350. https://doi.org/https://doi.org/10.1044/2014_aja-14-0011

9. Meibos A, Muñoz K, Schultz J, et al. Counselling users of hearing technology: a comprehensive literature review. *Int. J. Audiol.* 2017;56:903-908.
<https://doi.org/10.1080/14992027.2017.1347291>
10. Bennett RJ, Meyer CJ, Ryan B, Eikelboom RH. How do audiologists respond to symptoms of mental illness in the audiological setting? Three case vignettes. *Ear and Hearing.* 2020;41:1675-1683. <https://doi.org/https://doi.org/10.1097/aud.0000000000000887>
11. Bennett RJ, Eikelboom RH, Sucher CM, Ferguson M, Saunders GH. Barriers and facilitators to delivery of group audiological rehabilitation programs: A survey based on the COM-B model. *International Journal of Audiology.* 2021.
<https://doi.org/https://doi.org/10.1080/14992027.2021.1928304>
12. Bennett RJ, Barr C, Montano J, et al. Identifying the approaches used by audiologists to address the psychosocial needs of their adult clients. *International Journal of Audiology.* 2020;60:104-114. <https://doi.org/https://doi.org/10.1080/14992027.2020.1817995>
13. Parker D, Byng R, Dickens C, Kinsey D, McCabe R. Barriers and facilitators to GP–patient communication about emotional concerns in UK primary care: A systematic review. *Family Practice.* 2020. <https://doi.org/https://doi.org/10.1093/fampra/cmaa002>
14. Michie S, Atkins L, West r. *The behaviour change wheel: A guide to designing interventions.* London: Silverback; 2014.
15. Elrouby S, Tully MP. Using the Behaviour Change Wheel to identify interventions to facilitate the transfer of information on medication changes on electronic discharge summaries. *Research in Social and Administrative Pharmacy.* 2017;13:456-475.
<https://doi.org/https://doi.org/10.1016/j.sapharm.2016.06.002>
16. Henshall C, Taylor B, Goodwin L, Farre A, Jones ME, Kenyon S. Improving the quality and content of midwives' discussions with low-risk women about their options for place of birth: Co-production and evaluation of an intervention package. *Midwifery.* 2018;59:118-126.
<https://doi.org/https://doi.org/10.1016/j.midw.2018.01.016>

17. Biezen R, Grando D, Mazza D, Brijnath B. Why do we not want to recommend influenza vaccination to young children? A qualitative study of Australian parents and primary care providers. *Vaccine*. 2018;36:859-865.
<https://doi.org/https://doi.org/10.1016/j.vaccine.2017.12.066>
18. Ekberg K, Schuetz S, Timmer B, Hickson L. Identifying barriers and facilitators to implementing family-centred care in adult audiology practices: A COM-B interview study exploring staff perspectives. *International Journal of Audiology*. 2020:1-11.
<https://doi.org/https://doi.org/10.1080/14992027.2020.1745305>
19. van Leeuwen LM, Pronk M, Merkus P, Goverts ST, Anema JR, Kramer SE. Barriers to and enablers of the implementation of an ICF-based intake tool in clinical otology and audiology practice—A qualitative pre-implementation study. *PLoS One*. 2018;13:e0208797.
<https://doi.org/https://doi.org/10.1371/journal.pone.0208797>
20. Nickbakht M, Meyer C, Scarinci N, Beswick R. Exploring Factors Influencing the Use of an eHealth Intervention for Families of Children with Hearing Loss: An Application of the COM-B Model. *Disability and Health Journal*. 2020:100921.
<https://doi.org/https://doi.org/10.1016/j.dhjo.2020.100921>
21. Bennett RJ, Donaldson S, Kelsall-Foreman I, et al. Addressing emotional and psychological problems associated with hearing loss: Perspective of consumer and community representatives. *American Journal of Audiology*. 2021; Submitted May 2021.
22. Millar T, Goldberg D. Link between the ability to detect and manage emotional disorders: A study of general practitioner trainees. *British Journal of General Practice*. 1991;41:357-359.
23. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*. 2013;13:117. <https://doi.org/https://doi.org/10.1186/1471-2288-13-117>
24. Atkins L, Francis J, Islam R, et al. A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems. *Implementation Science*. 2017;12:77. <https://doi.org/https://doi.org/10.1186/s13012-017-0605-9>

25. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative research in psychology*. 2006;3:77-101. <https://doi.org/https://doi.org/10.1191/1478088706qp063oa>
26. Chew-Graham CA, Sharp D, Chamberlain E, Folkes L, Turner KM. Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: A qualitative study. *BMC Family Practice*. 2009;10:1-9. <https://doi.org/https://doi.org/10.1186/1471-2296-10-7>
27. Parker D, Byng, R., Dickens, C. & McCabe, R. “Every structure we’re taught goes out the window”: General practitioners’ experiences of providing help for patients with emotional concerns. *Health and Social Care in the Community*. 2020;28. <https://doi.org/https://doi.org/10.1111/hsc.12860>
28. Pollock K, Grime J. GPs’ perspectives on managing time in consultations with patients suffering from depression: A qualitative study. *Family Practice*. 2003;20:262-269. <https://doi.org/https://doi.org/10.1093/fampra/cm306>
29. Tarber C FL. Disclosure of mental health problems in general practice: The gradual emergence of latent topics and resources for achieving their consideration. *Communication & Medicine*. 2014;11:189–202. <https://doi.org/https://doi.org/10.1558/cam.v11i2.17404>
30. Ekberg K, Meyer C, Scarinci N, Grenness C, Hickson L. Family member involvement in audiology appointments with older people with hearing impairment. *International Journal of Audiology*. 2015;54:70-76. <https://doi.org/https://doi.org/10.3109/14992027.2014.948218>
31. Punch R, Hyde M, Creed PA. Issues in the school-to-work transition of hard of hearing adolescents. *American Annals of the Deaf*. 2004;149:28-38. <https://doi.org/https://doi.org/10.1353/aad.2004.0015>
32. West R, Michie S. *A Guide to Development and Evaluation of Digital Behaviour Interventions in Healthcare*. London, England: Silverback Publishing; 2016.

Table 1. Barriers and facilitators in capabilities of clinicians for asking about emotional well-being

Capability sub-domain, themes and corresponding sub-themes	B/F/M (N)
Physical capability	
Nil	
Psychological capability	
1. Knowledge of asking about emotional well-being	M (15)
• No knowledge of what questions to ask	B (3)
• (No) Knowledge of how to approach/ask about emotional well-being	M (4)
• No knowledge of how to guide the conversation about emotional well-being	B (4)
• Knowing about resources/where to find resource	F (2)
• Not knowing how to measure the psychosocial stuff	B (1)
• Not knowing the triggers to ask	B (1)
2. Skill	M (13)
• Not having the language to ask about emotional well-being	B (2)
• (No) counselling skills	M (5)
• Building rapport/trust with clients	F (2)
• (Lack of) skill of getting deep about emotional well-being	M (2)
• Asking about emotional well-being is difficult	M (2)
3. Forgetting	B (2)
4. hearing healthcare clinicians' awareness of emotional impacts of hearing loss	F (32)

- Awareness about different impacts on emotions and confidence F (11)
- Awareness about frustration and need for coping F (5)
- Awareness that clients may not bring their emotional issues up because of not knowing about the link between hearing loss and emotions F (4)
- Awareness of clients' difficulties with their significant others because of the hearing loss F (4)
- Awareness of stigma and social issues associated with hearing loss F (8)

Note. B: Barrier, F: Facilitator, M: mixed,

N: number of statements describing the phenomenon

Table 2. Barriers and facilitators in opportunities for clinicians for asking about emotional well-being

Opportunity sub-domain, themes and corresponding sub-themes	B/F/M (N)
Physical opportunity	
1. Time for asking about emotional well-being	M (7)
2. Tools	B (2)
Social opportunity	
1. Social influence from clients	M (44)
• (Lack of) clients' openness to questions about emotional well-being	M (26)
• If clients bring it up, audiologist asks about emotional impacts of hearing loss	F (4)
• Need for elaboration on questions about emotional impact questions to unaware clients	F (1)
• Clients distrust to qualifications of audiologist for mental health stuff	B (2)
• Cochlear implant clients more willing to express feelings than hearing aid clients	F (3)
• Male clients do not feel comfortable talking about emotions	B (2)
• Being a patient for an audiologist is difficult for some clients in certain professions	B (1)
• Lack of client awareness about audiologists' role in emotional stuff	B (3)
• Changes of clinicians and clients	B (1)
2. Supportive Peers	F (5)

3. Normalisation of discussions relating to emotional well-being (reduced stigma)	F (3)
4. Presences of significant others	F (5)

Note. B: Barrier, F: Facilitator, M: mixed,

N: number of statements describing the phenomenon

Table 3. Barriers and facilitators in motivations of clinicians for asking about emotional well-being

Motivation sub-domain, themes and corresponding sub-themes	B/F/M (N)
Automatic motivation	
1. Emotions associated with asking clients	M (12)
• Feeling comfortable (or not)	M (10)
• Anticipated regret	B (1)
• Feeling anxious	B (1)
2. Being in the habit	M (6)
3. Use of reminders/prompts	F (4)
Reflective motivation	
1. Beliefs about consequences	M (15)
• Necessary to get more out of the rehabilitation	F (3)
• Beliefs about advantages of uncovering emotional issues and not ignoring it	F (11)
• Do not believe in effectiveness of referral	B (2)
• Opening a can of worm	B (1)
2. Beliefs about confidence/capabilities	M (11)
• (Lack of) confidence in asking	M (8)
• Feeling fine to ask about emotional well-being	F (2)
• Belief in own capability to feel the vibe	F (1)
3. Beliefs that a person experiencing a life transition may require more mental health support	F (1)
4. Personal interest in the client as an individual	F (11)

5. Scope of audiology	M (5)
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Note. B: Barrier, F: Facilitator, M: mixed, N: number of statements describing the phenomenon

Table 4. Suggested solutions for asking about emotional well-being

Themes and sub-themes	Example quotes
1. Skills training	
• Example scripts/questions about how to ask about emotional well-being	“Examples help, so if I was with a tinnitus client, it’s like, how is that impacting you? Is that causing any anxiety, frustration? But I don’t ask those kinds of questions to a purely hearing loss client.” (C1)
• Appropriate language	“I don’t think that my language would be there just yet. I think I would need some training on it.” (C2)
• Getting into the habit of asking	“And it’s just maybe getting into the habit of asking.” (C5)
• Require training with assessment and Q & A to retain the skills	“Even though I dread to say it, maybe a little assessment at the end of time to make sure I’ve read it and retained it, just to reinforce those skills. And maybe, at some point, a Q and A again for those things, I tried this, but it didn’t work, or I’m not quite getting this bit here.” (C1)
• Clinicians’ awareness about the side effects of hearing loss	“It’s more the side effects, the anxiety and the depression, that get raised, so if the hearing is the major source of it, then I think it is incredibly important that we are aware of it and addressing it.” (C1)
• Role playing, hands-on training, and case study	“But not just a listening seminar. A hands-on, active, doing hands-on type of training session.” (C13)
• Observing a counsellor talking to a client	“I also do like to observe. Like maybe observing a counsellor doing something with an actual client.” (C10)
• Knowing how to calm clients down in the conversation	“... it would be helpful to know how to calm it down again after the tears.” (C6)
2. Specific resources to use	

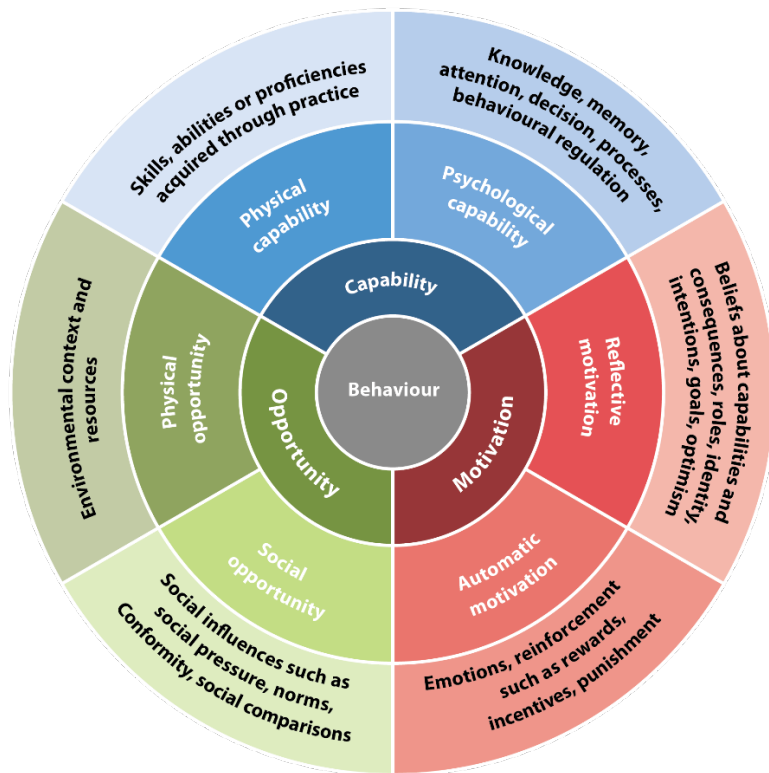
- Clear guidelines and protocols “A clear guideline just like we have with everything else ... that we know to look for and then we know how to refer them.” (C2)
- Printed information about emotional impacts of hearing loss “I find it easier to talk about the impacts of hearing loss if I have printed out sheets of the information in front of me.” (C7)
- A resource to structure the discussion around the emotional well-being “It’s a really difficult discussion. So, I think maybe a resource could be very useful to give some structure to that.” (C8)
- A resource to give clients “... some of the people they don’t know what they’re feeling because they can’t put it into words. It’s hard for some old bloke to come in and say that he’s feeling sad.” (C9)
- Access to peer-reviewed journal articles for clinicians “Everyone has different access to peer review articles, which I think is interesting, I did have a library access for a little while.” (C8)

3. Environmental changes

- Triggers/reminders (e.g., a checklist) “I’m not entirely sure what would be the trigger, but maybe when you do complete your notes, did you blah, blah, blah, at the bottom of it, and so the more you see that, the more you go, oh, I forgot to do that.” (C1)
- A few reinforcements “So often we get new thing rolled out, it’s in an email, read over that, and then a year later, you’re not doing it ... It needs to be reinforced maybe a few times over before these things really” (C1)
- Repetition and more practice with remembering to ask clients about emotional impacts “Repetition ... Doing more often and with everyone and having that strict thing that we follow.” (C2)
- Providing some questions to clients before appointments “Perhaps having more questions to think about. Not necessarily in the clinic, but at home, before or between appointments, that allows them to have a think and respond to emotional questions.” (C5)

- Emotional well-being as part of the case history “I think it should be part of the case history. Then it’s normal. It’s legitimate. It’s part of our job.” (C7)
- Time for training “Time for training, but also reminders to give it a go in the clinic.” (C7)
- Funding for extra time in appointments “I believe that there should be a cost but not the client ... it would be wonderful if Medicare could support us but that’s not currently how it works.” (C6)

Note. C: Clinician



Supplementary Figure 1. COM-B model of behaviour change, a framework for identifying barriers and facilitates to health behaviour. Adapted from “Application of the COM-B model to barriers and facilitators to chlamydia testing in general practice for young people and primary care practitioners: a systematic review,” by L.K. McDonagh et al., 2018, *Implementation Science*, 13, p. 3 (<https://doi.org/10.1186/s13012-018-0821-y>).

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Supplementary Topic Guide. Interview topic guide using the COM-B model

Opening questions	
Nature of the behaviour	<ul style="list-style-type: none"> • How do you currently ask your clients about the impact of their hearing loss on their emotional well-being? • What percentage do you refer for specialist mental health support? • In your practice, what would be your estimate of the percentage of clients experiencing mental health concerns?
COM-B Component	
Psychological capability	<ul style="list-style-type: none"> • What is your understanding of the emotional and mental health impacts of hearing loss? • Are you aware of any guidelines about how to support your clients with their emotional and mental health needs? • How easy do you find it to ask your clients about the emotional impacts of hearing loss? • Is asking your client questions about the emotional impacts of their hearing loss an automatic part of your job or does it require effort? Tell me more. • How do you know when it is appropriate to ask clients about how their hearing loss has impacted on their emotional well-being?
Social Opportunity	<ul style="list-style-type: none"> • How might the views/opinions of others (colleagues, managers, patients, professional groups) influence your decision to ask about or provide general information about the emotional and mental health impacts of hearing loss? Would you be more inclined to do this if more of your colleagues were doing it? • How do you think GPs/psychologists would respond to receiving a referral from an audiologist/audiometrist regarding mental health symptoms? • If you were unsure how to help a client of yours who was reporting emotional distress, who would you approach for support?
Physical Opportunity	<ul style="list-style-type: none"> • Do you currently have sufficient time to ask about and provide information regarding the emotional and mental health impacts of hearing loss? • If you had unlimited time for your appointments, would you have sufficient resources/systems in place to enable you to ask about and provide information regarding the emotional and mental health impacts of hearing loss? • Do any aspects of your clinical environment prohibit you from asking about and providing information on the emotional impacts of hearing loss and appropriate treatment/management options?
Reflective Motivation	<ul style="list-style-type: none"> • How do you think your clients would respond to you asking about the emotional impacts of hearing loss? • Do you feel that asking about the emotional impacts of hearing loss is within your scope of practice?

Automatic Motivation

- How does asking about the emotional impacts of hearing loss fit within the broader role of providing audiological rehabilitation?
 - How confident are you in your ability to ask clients about the impacts of hearing loss on their emotional well-being? What skills would you require to start doing this tomorrow?
 - When you think about the audiology profession, do you see us providing emotional and mental health support to our clients as routine services in the future?
 - What might be the advantages and/or disadvantages of asking your clients about the emotional impacts of hearing loss?
 - What do you think might happen if you ignore the emotional and mental health symptoms displayed by your clients?
 - When you start your day, do you have intentions to ask your clients about how their hearing loss has impacted on their emotional well-being? Then what happens?
 - Are there currently any incentives/rewards/punishments/consequences for you to ask your clients about how their hearing loss has impacted on their emotional well-being?
 - How do you feel about asking your clients how their hearing loss has impacted on their emotional well-being? Do you have any worries or concerns about it?
 - Does knowing that your clients are experiencing mental health symptoms, but not getting any support worry you?
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Supplementary Table 1. Barriers and facilitators in capabilities of clinicians for asking about emotional well-being

Capability sub-domain, themes and corresponding sub-themes	B/F/M (N)	Example quotes
Physical capability		
Nil		
Psychological capability		
1. Knowledge of asking about emotional well-being	M (15)	
• No knowledge of what questions to ask	B (3)	“I don’t know exactly what to be asking.” (C1)
• (No) Knowledge of how to approach/ask about emotional well-being	M (4)	“I think I’m more likely to ask if I know how to follow up on it.” (C5)
• No knowledge of how to guide the conversation about emotional well-being	B (4)	“I’m okay at acknowledging the initial issue that comes up, but I don’t know how to finish that discussion.” (C1)
• Knowing about resources/where to find resource	F (2)	“I thought it really makes a huge difference to me if I know what resources I can jump off into in response.” (C5)
• Not knowing how to measure the psychosocial stuff	B (1)	“I’m not comfortable talking about the psychosocial stuff because I can’t measure it.” (C7)
• Not knowing the triggers to ask	B (1)	“I’m not entirely sure what would be the trigger” (C1)
2. Skill	M (13)	

• Not having the language to ask about emotional well-being	B (2)	“I don’t have the wording, sometimes, to leave that conversation.” (C1)
• (No) counselling skills	M (5)	“I don’t feel like I have the skills to necessarily get too deep in there.” (C3)
• Building rapport/trust with clients	F (2)	“I think it comes quite naturally when you can build rapport with them.” (C4)
• (Lack of) skill of getting deep about emotional well-being	M (2)	“I start talking about their family ... then I would go, okay, so you’ve mentioned the family situation, how do you go hearing in that situation? And a lot of them will say, well, I can’t understand it when they all started talking at once or they crosstalk. Then I’ll say something like, that must be frustrating for you. And, then they’ll go, yes, but I can’t expect them to stop and not talk like that, essentially. So, it just develops in that way for most people.” (C3)
• Asking about emotional well-being is difficult	M (2)	“I don’t find it hard to ask them.” (C2)
3. Forgetting	B (2)	“I feel like there’s so much to remember and that’s not one of them. You sort of forget about it.” (C2)
4. hearing healthcare clinicians’ awareness of emotional impacts of hearing loss	F (32)	
• Awareness about different impacts on emotions and confidence	F (11)	“I definitely see a lack of confidence. Many of them report that they don’t feel confident going back into those meetings and so on.” (C14)
• Awareness about frustration and need for coping	F (5)	“I’ve got one client; he gets so frustrated with his own inability that it actually leads to quite anxiety in him.” (C9)

- Awareness that clients may not bring their emotional issues up because of not knowing about the link between hearing loss and emotions F (4) “I think that they really probably do feel the impact of it, but they just don’t recognise that it may be related to their hearing loss and therefore that’s why it doesn’t really come up in conversation.” (C6)
- Awareness of clients’ difficulties with their significant others because of the hearing loss F (4) “Yes, [my clients say] things like I don’t sit in the same room as my partner anymore because we can’t hear the same thing on the TV.” (C12)
- Awareness of stigma and social issues associated with hearing loss F (8) “Especially the older generation have that concern about the stigma associated with the anxiety.” (C6)

Note. B: Barrier, F: Facilitator, M: mixed, N: number of statements describing the phenomenon, C: Clinician

Supplementary Table 2. Barriers and facilitators in opportunities for clinicians for asking about emotional well-being

Opportunity sub-domain, themes and corresponding sub-themes	B/F/M (N)	Example quotes
Physical opportunity		
1. Time for asking about emotional well-being	M (7)	“Breaking down the distrust [for our profession] is sometimes a hard thing to do in an hour.” (C3)
2. Tools	B (2)	“If someone’s going to bring up an emotional concern within an appointment, I want to have the tools to address that effectively.” (C8)
Social opportunity		
1. Social influence from clients	M (44)	
•(Lack of) clients’ openness to questions about emotional well-being	M (26)	“Some are ready to tell you ... But then you get others that are not open to it at all.” (C3)
•If clients bring it up, audiologist asks about emotional impacts of hearing loss	F (4)	“Generally, my clients start the discussion, I listen to what they’re saying and as soon as I hear something like that, then I’ll start questioning more.” (C9)
•Need for elaboration on questions about emotional impact questions to unaware clients	F (1)	“There is a question in amongst the history where we ask them to write the impact, and often, they don’t know what you mean by that. So that’s where I would elaborate and say, how does it affect you? Do you get frustrated?” (C5)
•Clients distrust to qualifications of audiologist for mental health stuff	B (2)	“People come in and be like, are you qualified, what are your degrees?” (C3)

<ul style="list-style-type: none"> • Cochlear implant clients more willing to express feelings than hearing aid clients 	F (3)	<p>“... the implant clients are much more willing to express how they’re feeling ... whereas my hearing aid clients will come in and go no I’m fine, my family are saying that I’m not hearing well but I’m fine.” (C11)</p>
<ul style="list-style-type: none"> • Male clients do not feel comfortable talking about emotions 	B (2)	<p>“... they [males] have been more reserved in terms of expressing their concerns.” (C6)</p>
<ul style="list-style-type: none"> • Being a patient for an audiologist is difficult for some clients in certain professions 	B (1)	<p>“If they [GPs and highly qualified academic people] become your patient, I can often see how they find it difficult to be the patient because they’re so used to having the patient in front of them.” (C14)</p>
<ul style="list-style-type: none"> • Lack of client awareness about audiologists’ role in emotional stuff 	B (3)	<p>“Some people feel safer when you do keep it within the realm because some people are like, why are you asking me this?” (C1)</p>
<ul style="list-style-type: none"> • Changes of clinicians and clients 	B (1)	<p>“With COVID, we’ve had a lot of changes of clients and less continuity ... You can go through the notes, but you still don’t actually gauge [unclear] and that relationship, and what exactly was the most important points necessarily from the notes if you have time to look at the notes. So, I think a lot of that is missed with clients changing clinicians.” (C10)</p>
<p>2. Supportive Peers</p>	F (5)	<p>“We mentor each other, and we learn from each other.” (C14)</p>
<p>3. Normalisation of discussions relating to emotional well-being (reduced stigma)</p>	F (3)	<p>“I guess if you normalising, it does become easier.” (C3)</p>

4. Presences of significant others F (5) “Normally when there’s a significant other there it’s a bit easier.” (C3)

Note. B: Barrier, F: Facilitator, M: mixed, N: number of statements describing the phenomenon, C: Clinician

Supplementary Table 3. Barriers and facilitators in motivations of clinicians for asking about emotional well-being

Motivation sub-domain, themes and corresponding sub-themes	B/F/M (N)	Example quotes
Automatic motivation		
1. Emotions associated with asking clients	M (12)	
• Feeling comfortable (or not)	M (10)	“It starts off well, but I think it always ends awkwardly.” (C1)
• Anticipated regret	B (1)	“I would feel really horrible that I didn’t help them, knowing that I could have helped them.” (C2)
• Feeling anxious	B (1)	“I think that anxiety on the clinician’s part of not quite knowing what to do.” (C8)
2. Being in the habit	M (6)	“I’m just not in the habit. Don’t really think to ask it.” (C1)
3. Use of reminders/prompts	F (4)	“They fill that [rating scale of hearing loss impact on quality of life] in, but if they don’t fill it in, then once it comes up in our case notes, I notice it’s not filled in and I ask them again and have a discussion about it.” (C2)
Reflective motivation		
1. Beliefs about consequences	M (15)	
• Necessary to get more out of the rehabilitation	F (3)	“If we start incorporating it [asking about emotional well-being], they will get more out of the program.” (C2)

- Beliefs about advantages of uncovering emotional issues and not ignoring it F (11) “If we’re talking about it from human point of view, it’s having a big impact on them and their families.” (C3)
 - Do not believe in effectiveness of referral B (2) “Because my feeling is, even if they go to a psychologist, we don’t usually hear back.” (C5)
 - Opening a can of worm B (1) “I think it feels a bit like opening a can of worms ... it depends on who you’re asking that question to and what time is going to go into that answer.” (C8)
2. Beliefs about confidence/capabilities M (11)
- (Lack of) confidence in asking M (8) “Most of the time I probably wouldn’t have the confidence to bring it up myself, I would feed off them.” (C6)
 - Feeling fine to ask about emotional well-being F (2) “I feel absolutely fine to ask it [about emotional well-being].” (C2)
 - Belief in own capability to feel the vibe F (1) “I guess it depends on that, how ready they are to come in. I feel like you just read that as just another person. I don’t think you really need them to say anything specific or fill out a form. I think it’s just like a vibe.” (C2)
3. Beliefs that a person experiencing a life transition may require more mental health support F (1) “But what I sometimes get amongst young people who have just left school, or they’ve started to work ... they’ll come in and say they can’t hear, and their hearing is so much worse than what it used to be. And then if you look into it, it’s their listening environment that’s changed, and there’s so much more work pressure on them and that’s what they’re actually struggling to deal with.” (C14)
4. Personal interest in the client as an individual F (11) “Even if I know them a little bit, I like to find out a bit more about them on a personal level, and then I can start to dig deeper into the emotions.” (C14)
-

5. Scope of audiology

M (5)

“I think asking in relation to hearing loss or symptoms of balance and tinnitus, I think yes. We can ask about the emotional impact that that’s having.” (C5)

Note. B: Barrier, F: Facilitator, M: mixed, N: number of statements describing the phenomenon, C: Clinician