Case Planning in Tinnitus Management

Presenter: Mark Partain, AuD

At this time, it's my pleasure to welcome to Audiology online Our presenter, Dr. Mark Partain. Dr. Partain is an audiologist and tinnitus management specialist with over two decades of personal experience living with tinnitus. He earned his Doctor of Audiology degree from Rush University and built his expertise through clinical roles at North Shore Audio Vestibular Lab outside Chicago, Illinois and at Treble Health.

In the interest of time, I would invite you to visit our website and read more about Dr. Partain. But at this time I'll turn the microphone over to him for our presentation.

Thank you.

There we go. So these are my disclosures. I don't have anything to disclose.

There are limitations and risks of this presentation. I'd encourage you to read these. You know, the, the content is very individual for what we're going to be talking about today, specifically in tinnitus management. And then these are the learning outcomes. We're going to explain how to create individualized tinnitus management plans, use some case formulation, worksheets, things like that.

I'll be discussing effective communication, how to effectively communicate realistic management options and set treatment expectations. And then the last part, we'll be talking about developing and implementing a safety plan to reduce patient distress and manage tinnitus related emotional crises. I mentioned with that just a little bit of a content warning. We are going to talk about suicidality with it. That is the focus of safety plans.

So when we get there, I'll mention it again before we get started. So I always start with why we need to do comprehensive case management and planning. Really for me, it's often to resist the urge to jump right in. Usually patients that we are working with who are coming to us specifically for tinnitus

management, they may have seen several providers, you know, urgent care, primary care, Dr. Ent, maybe another audiologist before they're coming to someone that specifically is there to talk to them about tinnitus.

So often they come in with a thousand questions they want to ask, they want to get right into it. And honestly, as a clinician, I want to be able to show that I can provide some relief to them, give them some useful strategies. But if we kind of move past the planning stage early, we lose that ability to establish clear expectations, realistic expectations for what the outcomes of tinnitus management look like. And then one of the aspects that we missed there is really building that patient clinician collaboration and therapeutic alliance that we'll get more into a little bit later, but can really be helpful in that first appointment, can establish the tone for the whole relationship that we have. So what we really want to do is define our goals, improve our long term outcomes by having clearly defined goals, and altogether that is going to improve patient satisfaction.

So before we even just jump right into saying, okay, how do we plan a case with a patient with tinnitus? I kind of think that we need to take an even further step back and essentially say before that patient's in the office, before they're even on the schedule, hopefully. We need to look at what our options are, what our protocol looks like, to be able to both explain that to the patient, but also to be able to be clear with ourselves of what options we have on the table, where we're referring, and where our tools are as well. So the, at the first part of that discussion, I always like to begin with essentially that sound therapy alone, if that is the whole protocol that we have, is usually insufficient as audiologists. It's usually the first step that we have.

You know, whether it's hearing aids, amplification, cochlear implant, you know, we start with the audiologic side of things. But. But tinnitus distress involves more than just auditory perception. And that's why I will be using a lot the term tinnitus distress. Because it's not just the sound that people hear

in their ears, and that distress aspect of it can impact them emotionally, psychologically, socially.

We'll also talk about. And so relying solely on sound therapy ends up risking leaving components of tinnitus distress unaddressed and may even make the patient feel like, oh, all there is to do is put some sound into my ears and that's all we can really do to manage this. When in reality, there are a lot more options out there. And beyond that, the options that we have get stronger as we combine them together. So I pulled together a little bit of evidence supporting this multimodality kind of approach combining audiologic and psychologic interventions.

Anna Cam in 2023 had a good study looking at the efficacy of amplification for people with tinnitus and mild hearing loss. This study essentially found that amplification plus counseling significantly reduced tinnitus severity compared to counseling alone. So the message that I want to send with this one is don't throw the baby out with the bathwater. Even though we're going to be talking about a lot of, kind of the psychological side of implementing tinnitus, tinnitus management, we don't want to forget that the ears are really important in this process too. Counseling alone also is not sufficient for a lot of people.

Lou et al. Was a systematic review and network meta analysis where they looked at many different modalities of psychological therapy and counseling methods. Cognitive behavioral therapy, acceptance and commitment therapy, and then paired them with audiologic management. Essentially it showed that when you combine these treatments, everything becomes more powerful. Essentially the.

The CBT was good on its own. When you added sound therapy to that, it became even more effective. Same thing with acceptance and commitment therapy.

And then also a different lieu, different spelling, different group of people did another systematic review and meta analysis and showed that sound therapy with educational counseling consultation as well, consistently outperforms sound therapy alone. So even if we aren't going to be doing, you know, cbt,

which I would recommend digging into that because there are a lot of tools out there within the psychological and emotional management world that can be helpful. Education is a necessary component of it. And again, just adding that educational component outperforms just putting sound onto the ears, using amplification, or using sound therapy for the outcomes of those patients. So integrating approaches essentially leads to improved emotional regulation and coping, giving people more skills, more tools, a wider array of tools in their toolbox.

As I often say to my patients, increased treatment adherence and engagement because they feel like they're being heard and they're issues that they're having are being addressed and then enhanced quality of life outcomes. Particularly when it came to cognitive behavioral therapy. And really for acceptance and commitment therapy, the big change that they tended to see was improved quality of life outcomes that that would go along with the improvement in tinnitus that sound therapy can provide.

So with this information saying that, you know, we need to pull together several different options and different ways of thinking about tinnitus management, both psychologically counseling wise, audiologic. How do we develop our own protocol? This is going to be highly individual. I'll show you what I do. But, you know, everyone's going to be a little bit different and it should align with the clinician's comfort level and clinical expertise.

I've taken a bunch of continuing education courses on different counseling methods to develop some of the tools that I use. I don't think that you need to go as deep into it as possibly I did because I was writing a protocol and writing a book on that protocol. But I do think that kind of learning what we can about these treatment methods, you know, doesn't necessarily go outside of our scope of practice just to learn that. And that gets to the next point, define our scope of practice. I'm lucky I'm in Indiana.

Indiana has a very broad definition of what an audiologist can do in tinnitus management. I'm essentially able to do any non medical, non surgical treatment for tinnitus. And so I find that to be broad

enough that I can really expand the tools that I have. But should should both consider what your licensing scope of practice is, what your comfort scope of practice is. But beyond all of that, knowing our scope of practice can also kind of identify what limitations we have and where we might want to refer out to other clinicians.

Finding psychologists in the area that are comfortable working with tinnitus, psychiatrists that are familiar with it and familiar with some of the kind of medication aversion that comes with tinnitus management as well can be really helpful. So I always say that our protocol should address both auditory components using sound therapy amplification, but then also psychological and emotional components as well. I also recommend highly personalizing the approach as we go into how I do this. In the next few slides you'll hopefully see that every patient's going to get a different kind of protocol or way that my protocol comes together with them. What we're picking and choosing to go to bring together for those patients are dependent on their experiences.

But by doing that I'm able to get more clarity for my patients on why I'm doing what I'm doing. And also it does provide a lot of buy in from them that they can see that their concerns are being addressed by the options that we're deciding to utilize. Overall, it should improve our treatment outcomes. So an example of my clinical protocol, we won't go into all of this. I've been posting on LinkedIn quite a bit about this and I've got articles on just about every one of these emotional interventions that I use.

If something stands out to you, we aren't going to go into really any of those in detail of actually how they're implemented. But I tend to look at tinnitus management as having three major types of intervention. We've got our auditory interventions, our emotional interventions, and throughout all of that, we're educating the patient on why we're doing what we're doing, how it should be impacting them. The justification for everything that we're doing, auditory interventions will look kind of familiar to people. Sound therapy is usually what I start with.

Some colleagues that I have that have been doing a lot of neuromodulation have encouraged me to include that in here. So linear is an option for me. Amplification as well. At my practice I don't do devices and so I typically will find someone Locally, if someone has a hearing loss and recommend that they go there, they can also get neuromodulation devices linear locally as well. So the emotional interventions that I typically use we will go into in a few slides kind of how I pick and choose these.

But I've found that these are kind of different lessons almost that I can teach patients. And then at the bottom of it, we do have these administrative modules, case formulation, like we're talking about right now. And then another thing I feel like we don't do very strongly in tinnitus management is talk about case conclusion, long term management. What does that look like for people? And so this is what my protocol is again doing kind of telehealth, non device tinnitus care is going to look very different than the way that yours might look.

But it just kind of gives an example of what actually fleshing out something like this looks like.

So I can go back to this basically because I'm going to say I don't just print this out and hand it to a patient though as much as I'd love to show off the work that I did with this, it is much more focused in kind of clinician education, the fact that I kind of built this visual. The next question is how do we explain this? How do we explain the options that we have to our patients? And that is how I begin using some other tools to explain this. The biopsychosocial model is used in pain management.

That's where I was familiarized with, is a model of disease understanding that I think applies well to tinnitus. Essentially saying that there are biological factors, psychological factors and social factors to many types of disease. Biological factors for tinnitus would be something like hearing loss, Meniere's disease, somatic tinnitus, if there's TMJ or neck issues that are involved in it, as well as, you know, the actual auditory perception of the tinnitus. Is it loud today? You know, that might be more involved with the biological processes that are going on in the body than it does with psychological or social factors.

Psychological, we're talking about anxiety, depression, those emotional reactions that we have, the cognitive processes like attention. This can be something like, you know, more obsessive compulsive tendencies that will come out for I often have patients say, yeah, I've had, you know, untreated, you know, subclinical OCD for a long time, but now I can't really control what's going on. That's really what we're talking about with attention. Also the way that we look at things with catastrophizing, using certain psychological coping strategies and kind of resistance when we feel those things as well. And then finally the social factors that play into tinnitus management.

I'm sure anyone that does tinnitus management would be relatively familiar with these kind of social factors. Interpersonal relationships, social networks that we have, work, work stressors as well. I will often see people when they are in kind of the worst of the experience with tinnitus, take a leave of absence from work, particularly working in, in telehealth. I also will see people, you know, the first time I meet them, they're sitting in a dark room, all the windows closed, you know, curled up, you know, under a bed, talking to me on their phone. And they'll say something like, yeah, I don't really go out anymore.

I'm worried about my tinnitus getting worse or other people won't understand it, or I'm worried about being exposed to more sound, something like that. And those are social factors that really impact people. And so we can start to kind of put together this big picture of how tinnitus distress is actually experienced by our patients. And using the biopsychosocial model is typically where my first worksheet that I use will come up. This is my biopsychosocial worksheet.

As I said. I've been working on a book on my protocol and the worksheets that I've got in here are from the book. They are a little bit more clinician focused in their explanations than the actual ones that I use with my patients. But the utility of this worksheet, and I'll give you a close up to it, I know it's probably pretty small on some screens that people are seeing. The goal is to provide a structured and standardized approach so that I can kind of, in a way that I know where the conversation's going to go,

be a little bit more open ended with this.

It facilitates better understanding for the patients of the kind of complexity of different factors impacting each other and then begins that collaborative dialogue so that the patient knows that I am basing treatment on what they're experiencing. They can also see on paper why I am making the clinical decisions that I'm making and kind of, again, as we were saying, buy into it a little bit more. So this is just a close up of the top of that worksheet really. It just breaks things down into three big categories. Biological factors, psychological factors and social factors.

Has a little bit of a prompt question, but I tend to find. When I'm here, people are ready to start explaining and start having me categorize things. What I've done is I've taken a patient who was really successful in her tinnitus management. I'll go into a little bit more of her background on the actual case planning worksheet that I have, but I've anonymized it a little bit. You don't want to see my handwriting.

So I've done a little bit of cleaning things up. But what we found for her, what fit into the biological factors is that she had a moderate hearing loss. She had fluctuating tinnitus and sleep trouble as well. All of those I kind of looked at as biological factors for her. For psychology, psychological aspects, we're talking about increased anxiety that she was feeling.

This particular patient had had tinnitus for a few years, and it had gotten a bit better. But she had reached out to me when she was having an upswing in everything. And one of the ways that she kind of most tangibly felt that was the worsening anxiety and the sleep trouble. She was someone that kind of fell into that same obsessive thinking category. I put a lot of that into avoidance.

She would be online a lot researching tinnitus cures. Like I said, at the bottom of this supplements, she had tried a bunch of different supplements that were advertised to her vitamins, things like that online. And that kind of comes back to the obsessive thinking. I'll show how we can connect some of these on

the next. Next version of this slide.

And then the third thing that I felt like she. She was using for avoidance was over masking. She had done a little bit of a trial with sound therapy when her tinnitus first started. And the takeaway that she had, and so an educational opportunity that we had, was that she. She felt like masking was just covering up her tinnitus, which, using best practices, again, we're not really going to get into too much of what I mean by sound therapy, but if you look at best practices, we don't actually want to be covering up our tinnitus in that way for social factors.

She told me a little bit of a story about how in the first days of her tinnitus, her husband kind of said, yeah, I have tinnitus too. I don't get why it bothers you so much. Which is a really common story that we hear, is that people will find someone else with tinnitus that they know, and that person goes, yeah, but it didn't. Didn't ruin my life the way that it's, you know, turning yours upside down. She felt like, you know, she didn't have that support system of her husband.

And luckily she was telling this story basically saying, now we've talked about it through years of having tinnitus, she now feels a lot better with that she communicates better with her husband. But it's something in the back of her mind that she was worried about enough to tell me that story. And then since this upswing in tinnitus, she had also been avoiding social opportunities, not engaging in some of the things that she usually liked to particularly. She was a big book club person and she wasn't going to those anymore. So what I'll normally do after having these written down is I'll start drawing some arrows connecting things, showing people that it's.

It's not really purely biological, purely psychological or purely social. These things all overlap into each other. You know, the fluctuating tinnitus may be connected to the overmasking. There may be some sound sensitivity going on there that she isn't addressing yet. And that may be caused by turning sound therapy up just to try to block out her tinnitus avoidance altogether.

That avoiding social opportunities. That's where the psychological and the social really meet each other. And then the obsessive thinking. She was giving into that a lot with being on tinnitus talk in some of the forums out there. You know, when she couldn't sleep, she would just go online and spend all night thinking about this.

And, you know, rather than. One of the ways that I explain this to people often is I say we're doing a lot of talking about tinnitus management, but not actually doing much tinnitus management. That's the way that those forums work online a lot. It's a lot about talking about the experience, but not really about, you know, what am I doing to improve things. Both can be helpful, but it's when we start only doing one of those that things typically start snowballing a little bit.

So after I have that biopsychosocial worksheet, I've got some information I've got where she's feeling like her tinnitus is impacting her. And I'll typically move on to an actual formal case planning worksheet that I use. Again, it's a structured tool that gives us a good way to have some conversations about these things. It organizes the clinical decisions that I'm going to make and lets her let's really the patient, not specifically her, but lets the Patient become more involved in that. I have had some patients when I, I have, it's kind of like a checklist of the different topics that we can discuss.

And I've had patients who, I don't think that a particular topic is necessary for them who see that topic written out and they go, oh, that sounds really interesting. Can we add that in actually? And again, this is improving the therapeutic relationship that we're having, showing that it's a two way street. If they're interested in working on something, I'm interested in explaining to them what I know about it. And again, that educational aspect is a part of it.

I may not be giving them exercises to do in something that I think is just kind of a, a side interest of theirs. But I do want to educate them on how tinnitus might be impacting something like validation and

what would be another one like the social aspects of, of tinnitus and how we can better use tools to get through some of these social situations.

Again, enhances collaboration and it should improve our treatment outcomes. We're going to go into this after I show you the worksheet, but I've done a little bit of a mini dive into the psychological literature that has a good amount of information about how important improving communication in this first appointment is for the outcomes that we have.

So this is my case formulation worksheet. This worksheet again is, has kind of a clinician focused explanation at the top of it. I'll get rid of that top and fill it out with the patient's information. But in the case that you want to build something off of this, this is the kind of big picture that I have. And again, this is from the book that I'm editing right now on, on my clinical protocol.

Really it shows some open ended questions, place for notes and these modules are what I call them. They're essentially little topics that I can draw a little check mark if I think that it's going to be appropriate for that patient. So here we go. This is that patient again. Filled out the, the worksheet, filled out with them some more information about her.

She was 54 years old. She had had tinnitus for about three years. I think I mentioned that earlier. This was after that, that upswing in it and she had felt like she had really gotten better with it. It's not that it had gone away, but she was managing it much better.

You know, about two years into everything she said that she didn't think it would ever really become a problem again, which is why it Kind of felt like pulled out from under her when she did have this, this increase happen. Her chief complaints when she was meeting with me were sleep disruption. She really wasn't sleeping well, which was kind of the, the way that I talk about it in sleep management is bidirectional, you know, better improvement or improvement in sleep. Improvement makes

improvement in IDUs. Improvement in IDUs makes improvement in sleep.

And she was really feeling that she had noticed increasing anxiety due to the tinnitus getting worse recently and that moderate hearing loss. She had not pursued hearing aids back when she had initially had this problem. She kind of made the comment of feeling like, you know, they weren't really helping all that much. It didn't really address the problem that she was having at the very beginning of this. But the, the increase in tinnitus recently had made her say, okay, I need to do something about this.

And that's a big educational point that we can emphasize there too. Some additional notes on her. She was not having really interpersonal issues. Her husband was much more helpful the second time going through, but she was struggling with negative thinking pattern. I do a quick 15 minute call with people before we really get on the schedule and they pay for anything at my practice just to make sure it's an appropriate fit.

And she several times during that had just kind of seemed really down about the outlook for everything beyond that. Like I said, she had tried to use masking devices before but was not helpful for her. And so again, that was a big educational aspect that we can improve. So through all of this, I had selected sound therapy for her. So that was showing her how to use sound therapy correctly and really encouraging her to go to a local audiologist to try out some hearing aids, see if it was more effective now.

And she, she was pretty motivated to do that. Acceptance versus change is a topic that I always, I won't say always, but almost always will use for her, particularly with the supplements that she was trying. There was this avoidance aspect of that because if she's constantly trying to take supplements to get rid of tinnitus, she isn't really kind of making the movement forward that I feel like is necessary there. And so sometimes we feel this divide between acceptance and change and we need to be able to see that we need to accept what's going on. We need to accept that this tinnitus is here and there isn't a pill

that you can take to get rid of it in order to make change happen.

Cognitive reframing, which I picked for her, is just about that. Negative thinking that she was having self compassion validation. Same same sort of thing with that negative thinking. And then we talked about sleep management. She had actually seen a psychiatrist for, for sleeping medication.

And so that kind of played into that discussion too. But before I'll sometimes check these boxes I'll have a few more open ended questions. You know, what specific aspects of tinnitus does she want to improve? Fluctuations. She feels that it's tied to her emotions and anxiety.

Again that cognitive restructuring and reframing would be really helpful for her sleep. Sleep management. We can talk about that overall control. And what I wrote below that snowballing thoughts is something that term that I will use. This is where I start to build in my own terminology to it things that, that she or ways of talking about this that I'd like her to begin thinking about it.

That snowballing process, we can stop it early on. It's just about knowing what to do. What situations increase the tinnitus is the next question over here. Tinnitus feeling like it gets louder in the evenings. We'll actually come back to this topic when we're talking about safety planning for.

And then fluctuations again this is where I was using language that I like rather than language she likes. She uses the word spike. I do not like that word because it focuses on the increase but doesn't focus on the decrease that happens there. And so this is where I start to emphasize no, we're going to use fluctuation rather than spike here. And then from the notes, I believe I just pulled these from quotes that she had given in that initial 15 minute introduction meeting that we had.

She said I feel like I'm failing at this. That's really going to emphasize the self compassion and validation side of things. It is reasonable to feel like we've taken a step back. But at the same time we

can't really blame ourselves for that because she didn't do anything particularly to, to create the onset of this, this increased tinnitus. The other part that she said sounded really positive to me.

So I wrote that down. When I sleep well, my tinnitus is better. And so that gives us again going back to that overall sense of control that seems like we've got a lever of control right here. If we improve the sleep, we improve the tinnitus. So this is kind of how I put into place her particular story into my, into my case worksheet.

So as I said, I did a little bit of a dive into the psychological literature because there's more there than there is in Audiology or tinnitus management looking at the first appointment. That first appointment really matters. The initial appointment's crucial for establishing strong therapeutic alliance and it really does impact patient outcomes. The two studies that I pulled for this, Tyrion et al. From 2018, focused on goals, consensus and collaboration and how they impacted psychotherapeutical outcomes.

That study also focused mostly on early use of goals, consensus and collaboration in treatment and the outcomes that they provided. So they found that goals consensus, essentially client and therapist agreeing on the therapy goals, was strongly correlated to positive psychotherapy outcomes. So this would be a patient saying, well, I want to get rid of my tinnitus and essentially having to come back and say that's not a real goal that we can have. What I can do is try to reduce the distress that it causes and then collaboration again. Throughout this whole process, this has been kind of a collaborative conversation, asking the pat how they're experiencing their tinnitus and showing them how that informs our decisions.

That was also significantly correlated with positive outcomes. The other study that I pulled has probably my favorite title of the studies that I've got today. And it just kind of puts a fine point on everything, that that first session is the one that counts. This is an exploratory study on therapeutic alliance. They found what they were doing was essentially trying to evaluate therapeutic alliance after that first appointment.

And then it showed an association with clients, later adherence to their treatment and the treatment outcomes. The therapeutic alliance established during that initial session explained 32% of the variance in overall treatment outcomes when measured this down the road in follow up. So I'm hoping at this point it gives people justification for giving the time in that first appointment to really talk about this rather than just jumping into treatment, whether that is, you know, lenire or hearing aids. Talking to them about what's bothering them with their tinnitus will really help to set goals correctly, get them to the right referrals, which is some of what we'll talk about in the next little section that we have, and then finally really get them better outcomes because they're more involved in it and they're more kind of, as I've been saying, collaborative.

So this last section, again, I said I'd repeat the content warning. Safety planning has a lot to do with reducing suicidal intention or suicidal ideation and behavior. It is a topic that is uncomfortable for a lot of audiologists. That's why I find that directly addressing it is so important. That's going to be one of the themes for the, the rest of the, the, the Talk today.

Let me see on time. Good. I've got a few, few extra minutes. So I, I first came across the idea of like direct safety planning when I was taking a course on dialectical behavior therapy. Dialectical behavior therapy for people that don't know about it was developed for people with borderline personality disorder.

These patients back in the 80s prior, well, really prior to the development of DBT in the early 90s, were seen as some of the most difficult patients to work with. And particularly because one of the common factors is self harm and suicidality. DBT is really, really effective with it. And I'd recommend anyone that has any interest in learning about that digging into dbt. It really expanded my view of kind of how to take care of the whole person, even if I'm not using the actual strategies from dbt.

But the psychologist that was teaching the course that I was taking was talking about safety planning and had run a practice for patients with borderline personality disorder for over 10 years, had seen thousands of patients. I was just coming off of my time at the big telehealth practice, tinnitus practice that I worked at. And what shocked me with it was that his clinic that had been around for over a decade had the same number of suicides in their patients as we had had in I think four years of the practice that I was at. And it just kind of shows that, you know, if we directly address these things in a patient population where suicidality is increased to the general population, which we'll, we'll talk about here, that there are ways to directly address this, talk about it and make sure that we are staying in our scope of practice as well. So getting into actual safety planning.

What is it? Safety planning is an open, proactive discussion about safety, giving patients essentially a structured plan and some options to guide kind of high distress moments that they may be having. Why should we do it? Research. This was a study in Korea back from 2016 that looked at suicidality in people with tinnitus, showed that people with tinnitus have a significantly higher rate of suicidal ideation and suicide attempts compared to the general population.

Anyone that's worked with tinnitus will know that that's true. But this is an actual way we can put on paper and see that that is true. This is a particular aspect of the population that we're working with. The Stanley et al paper we'll get into a little bit more, but it shows that proactive discussion about this can significantly reduce the risks and the distress associated with it. With tinnitus Patients, they found that suicidal ideation was about twice as common as in non tinnitus, non people with tinnitus, I think is the right way to say that.

And suicide attempts were significantly higher, more prevalent for people with tinnitus as well.

One of the things I want to emphasize with this is that this is something for audiologists which is kind of uncomfortable to get into. It can be an uncomfortable conversation. And that's why I encourage doing it

on every tinnitus patient that comes through the doors, whether you have concern for suicidality or not.

I was giving a talk to an AUD program recently and going over safety planning for them and there was a student there that was kind of, I was trying to encourage some interaction going on rather than just a direct lecture. And one of the students told a story about, you know, a patient who is being seen to have hearing aids fit on them and they were alluding to not feeling safe, feeling suicidal, wanting to end their life at different parts of dealing with tinnitus. And a, the, the student didn't even say the word suicide. That's how uncomfortable with this topic typically we are. And B, the, the I asked what the clinician did and essentially they sidestepped the issue, focused on the hearing aid fitting and didn't really address that.

And again, I think this is just why we need to be a little bit better about this and more consistent so we get more comfortable with this topic. So our goal is to reduce immediate risk through outline proactive steps, foster patient empowerment so that they know that there are pathways to get help. And, and again, as we've been talking about throughout this whole presentation, we're building therapeutic alliance. This is also a topic where a lot of audiologists will say, whoa, Mark, this is way outside of our scope of practice. And I'd agree if I was saying that we should be doing the counseling for this.

Instead, what we're really trying to do is to very clearly outline where the scope of practice of audiology is and why we are not the appropriate person for a patient to come to if they are feeling feeling unsafe without saying you're on your own with it. So that, that Stanley et al paper to emphasize the efficacy of safety planning, this paper was a large scale study in emergency departments. They essentially found that there were 50% fewer suicidal behavior and suicidal behaviors in patients that received a structured safety plan. They also did a brief follow up call to check on the patients and that's compared to usual care. So that is a significant reduction in the amount of suicidal behaviors, readmissions, due to it.

What they recommended doing is having clearly outlined steps for managing crisis moments. And again this was emergency department. So these were people in true crisis when they were going through a safety plan and how to implement this better. The clinical implementation means that people get where they need to go sooner, they are safer, they feel more confident and it also encourages proactive clinician patient communication on this sensitive topic. Overall, the research showed that the safety planning interventions led to more than a double likelihood that the patients attended follow up mental health appointments.

And that reinforces the safety and improved clinical outcomes that we get from this. So I always like to start by focusing on defining the roles. The audiologist role is to recognize the signs of emotional distress related to tinnitus, to initiate the discussion about safety and then to provide resources and referrals to the right mental health professionals and also emergency professionals if needed. Mental health providers roles are to do the therapeutic interventions for emotional distress, anxiety, depression, the things that lead to suicidality. They conduct in depth psychological assessments and also can offer crisis interventions and ongoing support.

There is a wonderful protocol called CAMS C A M S Collaborative Assessment and Management of Suicidality. That is an incredible program. I would encourage anyone that is interested in getting better in this topic to watch some videos from CAMS providers and the people who created it. They also on their website have a list of their providers who have taken their training so that you can have a psychologist that you know in the area who's trained to work with people with higher incident rate of suicidality if you know they're showing up on the. I think it's a thi has that question on it that that asks about suicide.

You know who to refer out to in that type of scenario. The role of emergency personnel are to deal with acute crises and suicidal emergencies. They can prescribe medications, they can recommend

hospitalization, rapid stabilization of the patient. We want to say there are appropriate times to go to the emergency room here. And altogether this creates clear boundaries where you can really exemplify why an audiologist's role is not to do the jobs of those other providers.

I added this slide just to kind of start saying normalizing the conversation. As I said, I do this with every patient that comes through my doors. Our patients in tinnitus management have a higher risk of suicide. We need to address it that way. I've just kind of transcribed a few explanations that I have to patients.

It is kind of awkward the first few times, especially talking to patients where you have no concern for self harm or suicide for them to say you know what, we have to go through this right now. But just like anything else, just like any hearing aid programming that you do, the more you do it, the more comfortable you are with it, the more you end up with a script that you're comfortable, confident with and comfortable with. And so I, I have a few of these, these quotes that, that were just easy transcriptions that I had if people want more guidance there. So this is my safety plan again, taken from my, my protocol book that I'm working on. It's two pages long.

Really goes through some questions that the patients have. This is the patient that we've been talking about, the 54 year old woman that we did the biopsychosocial worksheet and the case planning worksheet with. And again, I really had no concern or her, but I still found it necessary to go through these steps. It took five minutes. Taught me a little bit more about her too, where her values are and so it's, it's valuable to do.

So we start step one, warning signs. Where are our warning signs that distress is elevating? She said. Feeling of tinnitus getting louder at night. Several nights of bad sleep or no sleep and feeling like no one understands what tinnitus is like.

That's what drives her to those forums a little bit, is to vent and to talk about it and hear people say, oh yeah, I've been dealing with the same thing too. I usually don't love those forums, but sometimes they are a good support community. Step two are coping skills, distraction skills. Like I said, she'd been to see a psychiatrist who had prescribed her a sleeping med that was used acutely. If she's had several days without sleep.

If she feels like she's really kind of has insomnia, like that wired feeling as bedtime comes up. She said also calling her best friend makes her feel really good again. As I was saying, I'm starting to build in what I know we're going to be talking about. We spent the second kind of half of the first appointment talking about sound therapy and I recommended coping skills, distraction skill. Let's use some sound therapy there.

Safe social settings for her. Even though it's not really a social setting, she loved watching a TV show at night. Really in a situation where we're stuck snowballing in our head, getting out of bed, turning on a tv. I know that there's all this stuff about blue light and I encourage people to look into the actual data for that because it's not as strong as we think it is turn on that TV show, get some distraction when we're talking about safety. That's the important part of it.

She has a bookstore nearby. She loves the book clubs in the evenings that they do for that. And then even though her husband had that initial issue communicating with her about tinnitus, she said, you know, in a situation where she felt unsafe, she knows that her husband would be there for support. Next part of this, supportive people. Her husband, like we just said, her best friend, who she said she could call on the phone, her mom, her daughter, the woman that runs the bookstore, book groups.

She said she knew she could always go in there and just have a conversation about something new that either of them is reading. And that kind of makes her feel better. Professional support. She did have a therapist. And one of the things I'll emphasize here is we actually write down the therapist

emergency number on this sheet.

We don't want the patient to have to go look this up when they're in a Crisis. Crisis line 988. Also 911. Even though my ones in this font look really weird, 988 is a suicide support line. They are wonderful.

It is a good resource to have. But in a true acute crisis, needing medication, needing anti anxiety meds, call 911, go into the emergency room, go to the hospital, like we said, go to the hospital. Her best friend, if I remember correctly, worked in mental health and she said, oh, she would know in the scenario that I need to go get help right then. Step six seems a little bit extreme when we say it out loud, but reasons for living, hopeful thoughts, things like that. For her, again, we didn't really have too much concern of suicidality.

She was saying, already it's gotten better already. Once she knows that it can get better. She just wanted to do it easier than the last time, which is why she was coming to me and that she was getting back to the things that she loved. Music, reading, family. And again, we want to actually write out these numbers, have them directly.

I will often tell patients if they don't have a safety plan that their therapist has done or that they've gotten done somewhere else, this would be the thing to print out and have somewhere tangible for them because you don't want to be searching for this when you're in a crisis.

So kind of pulling everything together here, our key takeaways. Comprehensive case planning is essential. It creates clear expectations, realistic expectations enhances that patient clinician collaboration and the therapeutic alliance that we're trying to build, especially in that first appointment it leads to more effective and personalized tinnitus management too. Which patients really respond to Multimodal approaches improve the outcomes. Sound therapy alone often isn't enough for these people and explaining to them that we understand that is also really important.

Incorporating those emotional strategies reduces tinnitus distress. And research supports using these multimodal, using modalities from different places and having ways to get patient support if we're not going to be providing that. Finally, safety planning is critical. Effective elevated suicidal risk for patients with tinnitus has been documented in the literature and anyone that works with tinnitus knows that that's true. This is an easy thing that we can do early on to make a big difference in the way that a patient responds to a true crisis.

Throughout all of this, I think that the running theme as I was building this presentation was that clear communication and education is crucial in it, we want to be able to address the emotional distress, but also the sound that people are dealing with. And as well in safety, it builds trust between you and the patient. Again in that safety planning aspect, defining professional roles, knowing who to refer out to when the patient shouldn't be coming to you for help in a crisis, things like that improve patient safety. So with all of that, I will pull up the Q and A and see if anything has. Ah, yeah, there's at least something an anonymous person asked.

Do you ever find that screening for suicidal thoughts actually brings up that fear in someone, creating more, if not less anxiety revolving around their tinnitus? How would you address this new anxiety? Yeah, I mean that is a risk of addressing this. I think that that's why, starting by saying I do this with every one of my patients because we want to make sure every one of my patients is safe. You know, I really haven't gotten too much pushback on that.

I think that especially in the day and age that we live in, everyone goes online searching around a little bit for tinnitus information. And one of the things that they see is that, that people do die from attributing the distress that they're experiencing to tinnitus. I mean the, the founder is a founder of Texas Roadhouse who, who passed away in 2021 was a very high profile case that pops up basically anytime you search anything about tinnitus. So yeah, I haven't run into that too much, but I could definitely

imagine that especially someone who's very stressed out, that might be a reason to spend the rest of the first appointment working on distress tolerance or something like that. What the right response to this is if they are worried about having those thoughts pop up, especially if they haven't yet.

I really find most patients that I work with on this are either like not engaged in, they're like, oh, well, that's me. I, I, yeah, I'll answer your questions, but let's move on from this part. Or they feel seen by it and understand it a little bit better. It seems the other question from Ann that I'm seeing is, can I repeat what CAM stands for? Yes, it's Collaborative Assessment and Management of Suicidality.

I'm blanking on the, the guy who created it his, his name. But if you want to watch an incredible video, if you look up Cam's suicide, it'll pop up. If you, he recorded this video that really explains how they look at suicidality differently. And it completely changed my view on how this can be addressed.

Oh yeah, David Jobs, he's the, the book on cams too is, is wonderful. I'm, I'm a reader and so when something like that pops up, I, I got the book read. Just really, you know, I'm more encouraged to send someone to a CAMS trained psychologist if, if they're needed because I've seen kind of how powerful that is.

James asked, in the past, I've had difficulty getting some patients to actually go to therapist after I've referred them. Do you recommend any methods to try to convince patients to see a psychologist? I think there is a little bit for me of confirmation bias with it because of what I do, because I don't do devices. I'm not your typical audiology practice. Most of my patients, patients are really open to kind of the counseling aspect of it.

One of the things that I found in the past though, has been really powerful, is kind of referencing again the limitations of our scope of practice and basically saying, you know what? Cognitive restructuring is one of the most used CBT skills that people would with in tinnitus management will use is kind of talking

about that. And if the patient comes back and says, hey, I really like that. I'm starting to see myself catastrophizing or filtering. I'll kind of emphasize that.

Yeah, if you want to dig deeper into that, there are great therapists out there, you know, and again, having your go to referrals and say, oh, this, this therapist that I know that's in town here is wonderful. Just go over for like an appointment with them, talk to them. What we're about, what we're talking about is really like keeping that momentum going a little bit. But No, I agree with you. It drives me crazy when people use me as a therapist.

That is not. Not our job here. And yeah, yeah, it's, it's. Can. Can be tough to convince people someone also asked, they're having trouble finding CBT therapists in their area.

How do I know they'll be appropriate? I tend to look for therapists that focus in the experiences that the patients are having. You know, if my patient's saying I'm having a lot of anxiety, I will look for someone that does anxiety management over, you know, someone that has its specific background in CBT that typically widens this. The. The kind of search range that I can find for it particularly too.

I will. If. If they're going to, to see someone that I haven't talked to a lot about tinnitus, like a provider that I'm referring to that hasn't talked. I haven't talked to them a lot about IDUs, or maybe they haven't seen a lot of people with IDUs. I will send an email over to them and say, hey, I'm starting to refer patients over to you.

The reason is because I saw your specialization in anxiety. That patient's probably going to show up and say, oh, no, I have tinnitus. I don't have anxiety. Which is just funny to me. But, you know, and basically say, they may basically be shorthanding saying, I have anxiety as I'm having my.

My tinnitus is really bothering me. Read that as I'm feeling really anxious today. And to show them that that connection is there is. Is really good. So it's, it's tough to find someone that specifically does CBT for tinnitus.

I know he's not the, the favorite of a lot of audiologists because he's not big into the audiology side of tinnitus management. But Bruce Hubbard, who has the website CBT for tinnitus is wonderful. He just doesn't really, you know, buy into the. The sound therapy component of it. He is still a great resource.

When I was working at the bigger kind of nationwide practice that I was at, I referred people out to him when they were, you know, let's say, in Idaho. It's hard to find someone nearby for that. So telehealth works really well. And, you know, since the pandemic, there are a lot more options out there for it. Any help is better than no help is the way that I think about that too.

Dr. Partan, thank you so much. This was such an informative webinar and so practical. All those resources you created and with your experience explaining I I love how you answered that first question about I I go over this with all of my patients like the Regarding the suicide, I just want to say too we have a course on Audiology online and I don't usually talk about other courses, but it is about it is from an audiologist, Lori Zatelli from University of Pittsburgh, after they had a patient who died by suicide. They did a lot of research on suicide and she put together this fantastic course and it's an older course course, but it is still great.

So if you're working with tinnitus patients and you want to learn more and so much of what you said today about what's in our scope and what's not and what we can say and what we couldn't say and how the student was afraid to use the word suicide and that kind of thing, I think people that wanted to delve in more should check out this course. It's called how to hear what your patients aren't saying, Recognizing the risk signs for suicide or self harm. But back to today's course. That was fantastic. We thank you very much.

I just want to remind our participants to complete the exam, if you're earning CEUs, it will show up in your account at Audiology online in about 10 to 15 minutes and it will expire within seven days. So Dr. Partain, we hope to have you back again. Thank you for this excellent course. Thanks for having me.

It's always great to work with Audiology online. And that wraps for today. Everyone have a great rest of your day.