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Level 3 Group Education



Chronic tinnitus usually is a permanent condition. In most cases tinnitus cannot be quieted, but patients can learn to manage their reactions to it. These reactions may need to be managed for a lifetime. Clinical intervention with PTM focuses on educating patients to become self-sufficient in managing their reactions to tinnitus.

This chapter provides a description of PTM Level 3 Group Education. Level 3 is the first level within the clinical hierarchy of PTM for which intervention specific to tinnitus is the primary purpose of patient visits to the clinic. During Level 2, the main focus is to evaluate and manage hearing problems, with a very brief assessment of tinnitus impact. (Fitting hearing aids at Level 2 to assist in the management of a hearing problem sometimes also results in a reduction in the impact of tinnitus, but this is not the primary purpose of fitting hearing aids at Level 2.) Intervention provided specifically for tinnitus during Level 2 is ancillary, such as answering questions and providing patients with educational materials.

Level 3 Group Education consists of a series of patient-education classes that are termed “work-

shops” because of their emphasis on interaction and participation. The standard protocol consists of five weekly workshops—two presented by an audiologist and three by a psychologist (or other qualified mental health provider). With respect to ordering the weekly workshops, it is recommended that the first and third workshops be those led by the audiologist, and the second, fourth, and fifth be those led by the psychologist.

The audiologist instructs patients in how sound can be used in different ways to manage reactions to tinnitus, and directs them through the process of developing individualized action plans using the Sound Plan Worksheet (Appendix N). The three workshops conducted by a psychologist provide instruction for patients to learn how to use specific coping skills to manage their reactions to tinnitus.

It should be noted that group education is not an appropriate venue for some patients, who may be unwilling to attend a group session or who may just require one-on-one intervention. Furthermore, if a patient has a cognitive impairment or other medical or mental health condition that would disrupt learning in a group education format, then the

information from the groups can be discussed with the patient and his or her significant other on an individual basis.

Self-Help Workbook

In Chapters 3 and 5 we described the patient self-help workbook *How to Manage Your Tinnitus: A Step-by-Step Workbook* (J. A. Henry et al., 2010a). The workbook is fairly comprehensive in that it provides a great deal of information to guide patients in learning how to self-manage their reactions to tinnitus. We have recommended that patients who participate in Level 3 Group Education receive a copy of the workbook when they attend their first workshop. In Chapter 5, we described reasons for waiting until Level 3 to provide the workbook. In general, it will be more effective for patients when used in conjunction with their participation in the workshops.

Collaborative Self-Management

As explained in Chapter 3, when referring to intervention for chronic tinnitus, we do not use the word “treatment,” which can imply that a provider performs some procedure (or administers a drug) that is intended to quiet the tinnitus of a patient who passively receives the procedure. We instead adhere to the notion that intervention should primarily involve educating the patient about *managing reactions* to tinnitus. Different strategies often are needed to manage reactions to tinnitus that occur in different situations. Patients need to learn these strategies so they can manage any life experience disrupted by the symptom. This learning should take place with a compassionate and knowledgeable clinician who provides the education.

The PTM approach to self-management is modeled closely after clinical methodologies recently developed for chronic pain management (Blyth, March, Nicholas, & Cousins, 2005). In the past, urgent pain relief depended on treatments such as opioid drugs or invasive surgeries. It now is recog-

nized that effective management of chronic pain depends much more on patients’ own efforts and expectations than on their passively receiving a treatment. In essence, biomedical solutions are being supplanted by educational approaches that focus on supporting long-term rehabilitation.

As patients become more actively involved in decisions affecting their clinical care, they naturally experience a greater sense of commitment to participate in the management process. This results in “a shift of responsibility from the health-care professional to the individual for the day-to-day management of their condition” (S. Newman, Mulligan, & Steed, 2001) (p. 1). Accomplishing this “shift of responsibility” requires working with patients to help them: (a) understand their condition; (b) participate in decisions regarding their management plan; (c) develop and follow the plan; and (d) monitor success of their self-management efforts and revise the plan as needed. The clinician and patient should maintain a therapeutic relationship, with contacts occurring either on an “as needed” or periodic basis (i.e., regular follow-ups). This overall approach appropriately is termed “collaborative self-management.”

Educating Patients to Use Therapeutic Sound

The use of therapeutic sound for tinnitus management is well supported clinically and by clinical research (J. A. Henry et al., 2008c). Evidence for sound-based tinnitus management has been reported for tinnitus masking (Folmer & Carroll, 2006; Hazell et al., 1985; Schleuning et al., 1980; Stephens & Corcoran, 1985), tinnitus retraining therapy (Bartnik et al., 2001; Berry et al., 2002; Herraiz et al., 2005; Herraiz et al., 2007), and neuromonics tinnitus treatment (P. B. Davis et al., 2007). In addition, hearing aids are well known to provide benefit for patients with tinnitus (Del Bo & Ambrosetti, 2007; Folmer & Carroll, 2006; Saltzman & Ersner, 1947; Surr et al., 1999; Surr et al., 1985; Trotter & Donaldson, 2008).

We completed two prospective clinical trials that involved fitting hearing aids, ear-level

noise generators, or combination instruments to most of the subjects (see “First Study” and “Third Study” in Chapter 2). All cohorts, regardless of the specific intervention involved, showed significant improvement (to varying degrees). Folmer and Carroll (2006) evaluated long-term outcomes in OHSU Tinnitus Clinic patients. Three groups of 50 patients each were evaluated who: (a) used ear-level noise generators; (b) used hearing aids; and (c) did not use ear-level devices. Although significant improvement was observed for all patients, those who used ear-level devices experienced significantly better outcomes than those who did not use devices.

An abundance of studies and clinical techniques support the use of therapeutic sound to manage tinnitus. It is important to note, however, that no one method has been shown to be superior over the others. With PTM, patients are not limited to a single method or a particular device. Rather, the approach is to provide patients with the knowledge and skills to use sound and sound devices in adaptive ways to manage any life situation disrupted by tinnitus. This is accomplished by teaching patients the different ways that sound can be used to manage reactions to tinnitus, and helping them develop and implement custom sound-based management plans that address their unique needs.

Workshops Conducted by an Audiologist

As mentioned above, Level 3 Group Education ideally consists of two workshops facilitated by an audiologist and three by a mental health provider. A PowerPoint presentation (*Managing Your Tinnitus: What to Do and How to Do It*) is given during each workshop (the two PowerPoint presentations made by audiologists are provided on the CD that is included with this handbook). The leader makes the presentations, facilitates discussion, and addresses any questions or concerns. The focus of the two Level 3 classes facilitated by an audiologist is to assist patients in learning how to self-manage their reactions to tinnitus using therapeutic sound in adaptive ways.

First Workshop (With Audiologist)

The goal for session one is for all group participants to use the Sound Plan Worksheet (see Appendix N) to develop an individualized “sound plan” for managing their most bothersome tinnitus situation. It is essential that participants learn how to use the worksheet to organize their efforts for using therapeutic sound.

The focus of education with PTM is to provide patients with practical, how-to information. The group sessions thus are task-oriented so the time must be spent teaching the participants what to *do* to manage their reactions to tinnitus. Covering all of the structured material during each session requires up to an hour and a half. Keeping these groups on-task can be challenging. There is a natural tendency for patients to want to share their experiences and thoughts about tinnitus, and they have limited opportunity to do that during the sessions. Also, any discussion about tinnitus inevitably leads to many questions. For these reasons, participants are asked to refrain from asking questions and discussing topics unrelated to the workshop until the end of the session. Discussion and questions relevant to the topics being presented are encouraged.

Review the Tinnitus and Hearing Survey

Prior to enrollment in group education, each participant should have filled out the Tinnitus and Hearing Survey (THS; Appendix D). As described in Chapter 5, the THS is designed to assist patients and clinicians in understanding how much of a patient’s problem is due to tinnitus and how much is due to hearing problems. It is critical for participants to have used the THS to determine candidacy for enrollment in Level 3 Group Education. In Chapter 5, a list of requirements was provided that should be used to ensure that a patient’s participation in Level 3 is appropriate.

If group participants do not bring their completed THS to the session, then they should complete one at the start of the session. The THS is then reviewed during the session—the concepts are discussed and participants are asked to share their

responses on the THS. This is done to ensure that all participants understand that the purpose of the classes is to address tinnitus-specific problems and that problems related to hearing are not addressed during the workshops.

Sound Plan Worksheet

Use of the Sound Plan Worksheet (see Appendix N) facilitates the process of identifying sounds and sound-generating devices that are expected to be effective in managing specific tinnitus-problem situations. The worksheet is used throughout the first session with the objective for each participant to develop a “sound plan” that will be used until the second session to manage the participant’s “most bothersome” tinnitus situation. After participants have gained experience and confidence with the process and the concepts of developing sound plans, then additional bothersome tinnitus situations can be addressed and more complicated and sophisticated technology can be incorporated. Participants are encouraged to use the worksheet on a regular basis to refine and improve their sound plans.

Creating a sound plan to address one problem situation involves four small tasks (No. 1 to 4 on the Sound Plan Worksheet) that likely can be accomplished successfully by patients: (1) identify a situation when tinnitus is problematic; (2) determine which strategy (or strategies) for using sound will be implemented in that situation; (3) determine a specific sound that will be used with each strategy; and (4) determine a specific device for presenting each sound. The plan is used for at least one week and then evaluated for its effectiveness (No. 5 on the worksheet).

Group participants are instructed to identify, using the Tinnitus Problem Checklist (see Appendix H), the life situation in which their tinnitus is the “most bothersome.” To increase the likelihood that the initial sound plan will be implemented successfully, they then create a sound plan to manage just that one situation using sounds and sound devices that are readily accessible. In this way, participants are empowered in creating a sound plan that can be implemented with minimal effort and usually at no cost to address their most bothersome tinnitus situation.

Three Types of Sound

To complete the Sound Plan Worksheet, participants must learn about the three types of sound (soothing, interesting, and background) that can be used to manage reactions to tinnitus. The three types of sound have been described in detail elsewhere (J. A. Henry et al., 2008c), and are reviewed briefly below.

Soothing Sound. Soothing sound is any sound that provides an immediate sense of relief from stress or tension that is caused by tinnitus. The use of soothing sound has its roots in the method of tinnitus masking, which originally was described by Vernon (1976). The method of tinnitus masking continues to be used, and relies on the use of ear-level “maskers” that generate broadband noise (Schechter & J. A. Henry, 2002). The use of sound with tinnitus masking is intended to provide an immediate sense of relief—not to “mask” tinnitus, as the name would seem to imply.

Soothing sound for tinnitus management is not restricted to the use of ear-level maskers and broadband noise. Any sound that produces a sense of relief (or that the patient considers soothing) can be used as soothing sound. When using soothing sound, it is important that patients focus on obtaining a sense of relief from stress and tension rather than focusing on how much their tinnitus is masked. We therefore decided to abandon use of the term “masking” altogether. Whether or not the tinnitus is masked is completely irrelevant to the use of soothing sound.

Interesting Sound. Interesting sound is used to actively divert attention away from the tinnitus. The use of interesting sound for tinnitus management has not been a part of any formal method of therapy for tinnitus. However, distraction is a concept that is used for pain management, and the use of interesting sound follows the basic pain model (M. H. Johnson, 2005). In essence, using interesting sound to manage reactions to tinnitus is intended to shift the patient’s attention away from the tinnitus and onto some other sound. Patients thus learn to “actively listen” to sounds that they find

interesting or entertaining, which accomplishes the distraction objective.

Background Sound. Some patients do not experience a satisfactory sense of relief from sound and so may be tempted to abandon its use altogether. It is important that patients understand that even if sound does not provide immediate relief (or if it is not interesting), it still can be very effective in managing reactions to tinnitus by reducing the contrast between tinnitus and the acoustic environment, thereby making it easier for the brain to let the tinnitus go unnoticed.

The “candle in a dark room” analogy is used to demonstrate the concept behind background sound (as shown on the video that is provided with this handbook). A burning candle in a dark room naturally attracts attention because of the high contrast between the flame and the dark surroundings. If the room is then lighted, the contrast is reduced causing the flame to attract less attention—even though it has not changed. This analogy helps patients to understand the purpose of using background sound.

The use of background sound for tinnitus management is derived from the method of tinnitus retraining therapy (TRT) (P. J. Jastreboff & Hazell, 2004), which started as a clinical technique in the late 1980s. The method continues to be used and relies on the use of sound to promote “habituation” (decrease in responsiveness) to tinnitus reactions and perception. Patients with more severe tinnitus are advised to use ear-level sound generators (or combination instruments). These patients are instructed to adjust the level of the broadband noise to below the “mixing point,” that is, below the level at which their tinnitus sound starts to change (J. A. Henry, Trune, et al., 2007a). Many of our patients and research participants had difficulty adjusting the sound to the mixing point, and often seemed generally confused and sometimes anxious about the mixing-point concept. The use of background sound is intended to accomplish essentially the same purpose as for TRT. However, we do not refer to the mixing point, habituation, or other terminology that is specific to TRT. In this way, patients learn what to do but are not expected to adhere to a protocol that can seem complicated

and daunting to accomplish. Patients certainly are encouraged to learn more about the TRT concepts if they are interested.

Demonstrating the Three Types of Sound

Specific activities were developed to give group participants the opportunity to experience each of the three types of sound. Visual scales are provided to enhance understanding of the activities (J. A. Henry et al., 2008c). The visual scales are demonstrated to participants during the first session so that they can appreciate their utility. Participants learn that they can use the tools on their own to evaluate the effectiveness of different sounds for ongoing tinnitus management.

The Relief Scale (Appendix O) was developed as a tool for PTM patients to use to (a) learn how soothing sound is used to manage reactions to tinnitus, and (b) identify sounds and evaluate their ability to induce relief. Patients listen to the demonstration sound and then answer the question, “How much relief do I feel?” The six-point response scale ranges from “no relief” (no reduction in stress or tension caused by tinnitus) to “complete relief” (elimination of stress or tension caused by tinnitus). Participants are asked to share their ratings with the group.

The Attention Scale (Appendix P) was developed for use during an activity in which patients learn how interesting sound can divert attention away from tinnitus. The scale is used as a tool to help patients identify the kinds of sounds that most effectively shift their thoughts away from the tinnitus. Patients are instructed to select any sound or sound passage that they would expect to keep their attention. After listening to the sound for at least one minute, they estimate the percentage of attention focused on the “interesting” sound versus the tinnitus. A sound passage is played during the workshop to demonstrate interesting sound, and participants are asked to share their ratings on the Attention Scale with the group.

The notion of reducing auditory contrast between tinnitus and sound in the environment can be demonstrated to participants using a visual analog. Tinnitus in a quiet environment results in high contrast. The addition of sound reduces the

contrast. Patients can hear this effect by first noticing how their tinnitus sounds in quiet, and then adding sound. The Tinnitus Contrast Activity (Appendix Q) serves as a visual analog to facilitate demonstrating this effect. Patients use the Tinnitus Contrast Activity while listening to different sounds. Although each sound reduces contrast by a different amount, patients are taught that any amount of contrast reduction can be beneficial—provided the sound is experienced at a comfortable level. One or more background sounds are demonstrated to the group, and participants are asked to relate the concept depicted by the analog to the effect that is achieved with the sound.

Sound Grid

For each of the three *types* of sound (soothing, background, interesting), environmental sound, music, and speech can be used. This results in nine possible combinations, as shown by the sound grid (Figure 7-1). *Environmental sound* includes any nature sound (sounds of animals, weather, moving water, etc.) or synthetic (manmade) sound (e.g., electric fans and appliances, broadband masking noise, synthesized sounds). *Music* of all styles can be used, including music with and without lyrics. *Speech* of all varieties is appropriate to utilize, including lectures, sermons, talk radio, guided imagery, crowd noise, one-on-one conversation, and so forth.

Case Example

A case example demonstrates how patients use the Sound Plan Worksheet (please refer to Appendix N). Mr. Roberts' most bothersome situation was "being annoyed by his tinnitus while working in his quiet office" (No. 1). As a general strategy (No. 2), he thought that using background sound might in general be helpful. The specific sound he would try would be constant fan noise (No. 3) from a small fan in his office (No. 4). He tried this plan for one week and determined that the plan was "a little" helpful (No. 5). He then revised his plan by adding soothing sound (No. 2). He liked sounds of nature and decided to listen to beach sounds (No. 3) using a CD and CD player that he already owned (No. 4). After trying a combination of fan noise and sounds of nature for one week, he indicated that the plan helped him "a lot" (No. 5). Mr. Roberts' initial sound plan demonstrated limited success. Based on that experience, he revised his plan and the new plan worked well for him. He experienced success using the worksheet to address one particular problem situation, and he now uses the worksheet as needed to develop plans to address other problem situations.

	Environmental	Music	Speech
Soothing	✓	✓	✓
Background	✓	✓	✓
Interesting	✓	✓	✓

Figure 7-1. Sound grid. This grid shows that there are three *types* of sound (soothing, background, interesting) that can be used to manage reactions to tinnitus. Each type of sound can involve the use of environmental sound, music, and/or speech to manage specific tinnitus-problem situations. A total of nine combinations of sound are possible as indicated by the nine checkmarks.

Second Workshop (With Audiologist)

At the end of the first workshop, group participants are asked to return for a follow-up workshop two weeks later. Between workshops, their “homework” is to carry out and evaluate the effectiveness of their initial sound plan. Participants should bring their worksheet developed at the first session to the second session. They are told that they can modify the plan during the second session to improve its effectiveness.

The objectives of the second workshop are for participants to: (a) share their experiences using their initial sound plan; (b) engage in collaborative problem solving (to address any problems implementing their sound plans); and (c) improve their sound plan or develop a new sound plan. In addition, new information is covered during the second workshop, including descriptions of: (a) different types of sound-producing devices; (b) ideas for using sound to improve sleep; (c) sound-based methods of tinnitus management and how they relate to the sound grid (see Figure 7–1); and (d) lifestyle factors that can affect tinnitus and hearing. Participants should attend both workshops to maximize their benefit. Participants who attend only the first workshop should receive follow-up by telephone.

Workshops Conducted by a Psychologist

Mental health intervention can be an important component of an overall approach to managing tinnitus for all patients. Patients who are bothered by tinnitus can, in general, benefit from receiving mental health intervention to alter maladaptive reactions to tinnitus and to aid in coping with tinnitus. Mental health intervention is particularly important for patients with tinnitus who also experience post-traumatic stress disorder (PTSD), depression, anxiety, or other mental health problems.

A major question in the development of CBT for Level 3 was the number of sessions that should be conducted. Six to ten sessions of CBT are typical in many clinical settings. The actual number of CBT

sessions is flexible, however, and depends on the purpose of the therapy. Beck (1995) explained that “Most straight-forward patients with depression and anxiety disorders are treated for 4 to 14 sessions” (p. 7). One controlled study has shown that a condensed version of CBT for tinnitus can be conducted in two sessions with no differences in disability reduction relative to a group that attended 11 sessions (Kroner-Herwig, Frenzel, Fritsche, Schilkowsky, & Esser, 2003). Consistent with a “progressive” approach to tinnitus management, patients should receive less intervention at lower levels and more intervention at higher levels. Therefore only certain components of CBT are taught at Level 3 so as to minimize the number of sessions that patients are expected to attend at this level of care.

We determined that three CBT sessions at Level 3 would be necessary to cover the most important components of CBT (described below). Patients then have the option of attending additional sessions if further CBT counseling is needed. These additional sessions normally are offered to patients following, and depending on the results of the Level 4 Interdisciplinary Evaluation. In addition, the Level 3 protocol is flexible such that if multiple participants in the CBT workshops require additional intervention, then additional workshops can be added—which again is consistent with the progressive approach.

Typically, in CBT when basic information about the problem is provided, this is called psychoeducation and usually is presented during the first session of CBT. The last session of CBT typically includes information about preventing the problem from recurring or getting worse. For example, when CBT is used to treat depression, during the last session patients normally are taught how to identify early signs of depression relapse (such as overeating) or how to prevent depression (such as exercising regularly). Psychoeducation and planning for flare-ups and exposure to loud noise during PTM is presented in the self-help workbook provided to each patient, and thus, this information is not repeated during the Level 3 CBT workshops with the mental health provider. Consequently, more than three sessions of CBT would create some redundancies using the PTM structure. However, all information (basics of CBT, psychoeducation, protecting hearing, and

flare-up planning) and the CBT skills addressing stress reduction, attention diversion, and cognitive restructuring are reviewed if the patient progresses to Level 5 Individualized Support.

Patient learning in all of the Level 3 workshops is facilitated by use of the PTM self-help workbook (J. A. Henry, Zaugg, Myers, & Kendall, 2010a). Each of the CBT components taught during Level 3 is described in the workbook. After each session, patients practice their new skills by using worksheets and activities in the workbook. These worksheets and activities are intended to facilitate learning the new skills and recording progress. When patients return for the next workshop, they are asked to report their progress to the group. Group education based on CBT, as opposed to individual CBT sessions, is efficient and allows patients to apply skills to a variety of situations and to develop a social network from which to draw support.

Changing Thoughts and Feelings Worksheet

During the CBT workshops the Changing Thoughts and Feelings Worksheet is used, which is modeled after and used simultaneously with the Sound Plan Worksheet (see Appendix N). The Changing Thoughts and Feelings Worksheet helps patients track their use of the three coping skills offered during the CBT portion of Level 3. The worksheets are used throughout the sessions with the objective for participants to develop personalized plans for managing their reactions to tinnitus in specific problem-situations.

CBT group participants are instructed to identify, using the Tinnitus Problem Checklist (see Appendix H), the life situation in which their tinnitus is the “most bothersome.” This is the same task that is required when they use the Sound Plan Worksheet during the workshops conducted by an audiologist. It is helpful if patients identify the same tinnitus problem on their two different worksheets to learn how very different strategies can be used to address a single problem situation. The audiologists and mental health providers who teach these workshops should point this out and ask partici-

pants to focus first on their most bothersome tinnitus problem. In the process, patients learn that managing reactions to tinnitus involves using a combination of strategies that each are developed and refined through trial and error. Learning to manage tinnitus is a process that should be conducted systematically—by learning the strategies, developing action plans, implementing the plans, and revising the plans to improve outcomes.

After the group participants have gained experience and confidence with the process and the use of CBT concepts to manage their reactions to tinnitus, they can use any of the skills as “tools” to help them cope with their tinnitus. They are encouraged to use the Thoughts and Feelings Worksheet on a regular basis to refine and improve their use of these coping skills.

Essential CBT Components

The Level 3 workshops led by a mental health provider focus on teaching three CBT techniques: stress reduction (“relaxation”), attention diversion (“planning pleasant activities”), and cognitive restructuring (“changing thoughts”). During the first CBT session, the basic premise that how one thinks and acts influences one’s feelings is described. Emphasis is placed on clarifying goals and tracking efforts. Later, patients learn techniques to assist them in learning ways to modify thoughts and increase or decrease behaviors that influence how they feel about their tinnitus. Each of these coping skills can be helpful to patients who want to learn ways to manage their reactions to tinnitus. These skills also are applicable to many other chronic conditions such as anxiety, depression, and pain.

CBT Session I

Stress Reduction

Many patients report that their tinnitus is exacerbated by stress. By reducing stress or managing reactions to stress, patients are able to reset the body’s natural stress arousal system to a more relaxed and calm state. Practicing relaxation tech-

niques can modify one's response to stress and can serve to distract attention from the tinnitus to other things. The goal of providing this skill is to empower patients with a simple and easy way to relax when stressed.

Relaxation techniques taught during the first session of Level 3 with the psychologist include controlled breathing and imagery. A video demonstration of these techniques ("Deep Breathing" and "Imagery") is included on the DVD that is provided with the self-help workbook. The "Deep Breathing" exercise is a controlled breathing exercise that helps patients focus on taking slow and rhythmic breaths. Controlled breathing encourages attention to the mechanisms of the lungs and sounds of breathing, which releases tension and diverts attention from tinnitus. The "Imagery" exercise teaches patients to imagine being somewhere calming and safe. Imagery is useful as a relaxation technique when a pleasant or neutral image is envisioned during distress (J. L. Henry & Wilson, 2001). These techniques also require practice, thus, patients are asked to complete "homework" between sessions.

Instructions for both of these relaxation exercises are specific for patients with tinnitus. For example, patients are instructed not to practice the relaxation exercises in silence. Patients are encouraged to use soothing sound such as calming music during the exercises. Furthermore, since many patients with tinnitus also have hearing loss, instructions take into account the fact that some patients may feel more comfortable not closing their eyes during the relaxation exercises. They are instructed to focus on an object in the room or on the open-captioning of the relaxation demonstrations on the video.

Attention Diversion via Increasing Pleasant Activities

There are many ways to divert attention from one activity to another. Many patients stop doing the things they like to do (pleasant activities) and tend to focus on required activities such as work and house chores. The goal of providing this coping skill is to help patients learn ways to divert attention away from the tinnitus and onto other things by increasing pleasant activities in their lives. This

skill also is taught during the first session of Level 3 with the mental health provider. The skill typically is easy for patients to understand.

Group participants are instructed to examine the impact of tinnitus on their activities, particularly on pleasant activities, and to learn ways to increase their activities. They are provided a list of types of activities (solitary, indoor, social, musical, etc.) from which to develop ideas about the types of activities they would enjoy. They then are asked to add one pleasant activity to their daily routine and rate how effective it was in diverting attention away from the tinnitus.

Increasing activities helps to distract patients from their tinnitus and helps them to gain meaningful experiences that typically result in a greater sense of relatedness and connectedness to the world. Also, patients may have become isolated over the course of learning to cope with their tinnitus. Some patients will need encouragement to become social again.

CBT Sessions 2 and 3: Cognitive Restructuring

During the second and third CBT workshops, the group participants are taught how their thoughts and behaviors influence feelings via a step-by-step guide for evaluating thoughts, modifying thoughts, and developing healthy attitudes. These cognitive restructuring activities require two sessions to adequately cover all the material.

CBT Session 2

During the first of the two sessions on cognitive restructuring, participants learn about healthy attitudes and examining their own thoughts; this sometimes is called "mindfulness" training. Mindfulness is a state of being consciously aware of one's own thoughts and behaviors. Some patients tend to use faulty logic when thinking about experiences.

During this session, participants learn the 12 most common types of negative appraisals (also called thought errors): (1) overgeneralization, (2) all-or-none thinking, (3) filtering or selective abstraction, (4) mind-reading, (5) magnification

or catastrophization, (6) minimization, (7) personalization, (8) jumping to conclusions or arbitrary inference, (9) emotional reasoning, (10) “should” statements, (11) labeling, and (12) blaming (Beck, 1995). They are taught to be mindful by systematically examining their thoughts so as to provide insight into which of these 12 negative appraisals they may be using. They are asked to cite personal examples for each of the 12 negative appraisals as homework. As they do this exercise, thought patterns or “habits” typically emerge, helping them understand their own thought processes.

CBT Session 3

During the second of the two sessions on cognitive restructuring, the participants learn to systematically modify or restructure their thoughts so as to create different, more desirable emotional reactions. Constructive approaches to stress, such as thinking of a stressful event as a challenge rather than a threat, are presented. Negative attitudes and appraisals of situations often lead to negative emotions, which immediately are applied to individuals’ unique problems and concerns.

During this session, step-by-step instructions are provided for changing negative appraisals to more constructive, positive appraisals. The group works through an example in their workbook of using the step-by-step process to address a negative thought about an event and come up with alternative, more constructive thoughts. The participants’ life situation in which their tinnitus is most bothersome as identified on the Tinnitus Problem Checklist (see Appendix H) is used during this exercise to keep the CBT sessions aligned with the sessions with the audiologist.

Post-Workshop Follow-Up

Patients who attend the workshops should be informed that they will receive a follow-up phone call approximately one month after the last workshop. The call is made by the audiologist or the mental health provider who conducted the workshops. The purpose of the call is to determine if the patient will return for the Level 4 Interdisciplin-

ary Evaluation. During the call, the clinician asks about progress implementing the action plans, discusses any problems encountered, and answers questions. The clinician can use any of the written questionnaires that were administered previously to assist in determining if a Level 4 appointment is warranted.

Conclusion

Any person who has tinnitus can benefit from being educated concerning what to do about the phantom sound. Many patients are interested only in a cure for their tinnitus, and they may not realize the importance of learning good management techniques. In general, clinical services for tinnitus are provided only to patients who are *bothered* by their tinnitus. The majority of individuals who experience tinnitus are not bothered by the constant sound and they mainly need to learn and adhere to good practices to avoid situations that can damage their hearing. Those who *are* bothered by their tinnitus need to learn methods to self-manage their reactions to tinnitus. With PTM, these methods include education about using therapeutic sound and effective coping techniques.

The goals of PTM are achieved through the process of *collaborative* self-management. Clinicians who provide PTM should consider themselves as a source of information and support that empowers patients to manage any situation in which tinnitus is problematic. As already discussed, collaborative self-management is very different from the traditional “treatment” model, which involves patients passively undergoing some kind of therapeutic procedure(s). The keys to collaborative self-management are the availability of appropriate educational materials and the means to provide the education to patients efficiently and effectively. The framework of PTM provides for a variety of modalities through which patients can learn the essential self-help information. Level 3 Group Education is sufficient for most patients who are bothered by tinnitus. If further services are required, then the patient should be scheduled for a Level 4 Interdisciplinary Evaluation, which is described in the next chapter.