Manualisation and feasibility of audiologist-delivered counselling for tinnitus

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Measuring tinnitus

- Connectivity in the tinnitus brain
- Questionnaire measures
- Psychoacoustic tests

Evaluating interventions

- Novel compounds
- Devices
  - Audiologist-delivered talking therapy
- Self-help programmes

Exploring therapeutic targets

- Effect of tinnitus on working memory and attention
- A new cognitive model of tinnitus

Evidence synthesis

Health service evaluation
• information/directive counselling
• hearing aids
• sound enrichment
• relaxation therapy
• psychological therapy (cognitive behaviour therapy)
• sleep hygiene techniques (inc. CBT)
• combinations that provide habituation therapy

Footnote (p5) : ‘This Good Practice Guide to the delivery of services is not, and does not aim to be, an evidence-based guideline for clinical practice with individual patients.’
“…….expanding the role of the audiologist with hearing rehabilitation expertise into the use of counselling.

Where clinical psychologists are available, they should be employed,…‘talking therapies’ will have an increased role to play in NHS care generally.

Where psychologists are not available, the audiologist’s role should extend to offering psychological treatment through CBT or other appropriate counselling techniques.”
Talking therapies

Cognitive Behaviour Therapy
- a structured, time limited approach (Martinez-Devesa 2010) which look for practical ways to improve state of mind in dealing with current problems.

Counselling
- aims to empower patients to reach decisions and take actions for themselves. Establishing a therapeutic relationship, clarifying and defining problems, planning actions, and managing expectations are all key features of the approach (Culley 2004).
A number of systematic reviews show efficacy of CBT for tinnitus (Martinez-Devesa et al., 2010 Cochrane Database of Systematic Reviews, Hoare et al., 2011 Laryngoscope, Hesser et al., 2011 CBT).
An important question

Whilst these and other approaches may have practical benefit for tinnitus patients many audiologists have concerns about what degree of training is appropriate in order to formally 'counsel'

(Gander 2011 BMC Health Services Research)

Tinnitus Priority Setting Partnership Top 10 unanswered questions

(Baguley 2013 Lancet)

<table>
<thead>
<tr>
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<th>Question</th>
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<tbody>
<tr>
<td>A</td>
<td>What management strategies are more effective than a usual model of audiological care in improving outcomes for people with tinnitus?</td>
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<tr>
<td>B</td>
<td>Is Cognitive Behaviour Therapy (CBT), delivered by audiology professionals, effective for people with tinnitus? Here comparisons might be with usual audiological care or CBT delivered by a psychologist.</td>
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<tr>
<td>C</td>
<td>What management strategies are more effective for improving tinnitus-related insomnia than a usual model of care?</td>
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<tr>
<td>D</td>
<td>Do any of the various available complementary therapies provide improved outcome for people with tinnitus compared with a usual model of care?</td>
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<tr>
<td>E</td>
<td>What type of digital hearing aid or amplification strategy provides the most effective tinnitus relief?</td>
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Purpose

Develop a manual for audiologist-delivered talking therapy and test its feasibility

What are the essential components of talking therapy for tinnitus that can be delivered by audiologists?

By definition, will be a ‘complex intervention’

– Several interacting components,
– Target a wide range of possible outcomes, which may have great variability in the target population,
– Have a permitted degree of flexibility or tailoring,
– Affect or require various behaviours of those receiving the intervention.
• Best practice is to:
  – develop systematically,
  – using the best available evidence and appropriate theory,
  – test them using a carefully phased approach, starting with pilot studies targeted at each of the key uncertainties in the design, and moving on to an exploratory and then a definitive evaluation.
  – ‘Users’ should be involved at all stages of the development, process and outcome analysis
Plan

SCOPING REVIEW → DELPHI REVIEW → MANUAL DEVELOPMENT → FEASIBILITY STUDY
Evaluating the available evidence

Step 1: scoping review

• course materials relevant to counselling or CBT for tinnitus or rehabilitation
• practice guidelines published by professional bodies (British Society of Audiology, British Academy of Audiology)
• clinical psychology practice guidelines,
• protocols from relevant clinical trials,
• grey literature including PhD theses,
• commentaries and professional magazine articles.

We will also look beyond audiology to examine how and when counselling is commissioned (in particular, examining models related to the NHS Improving Access to Psychological Therapies initiative, iapt.nhs.uk).
Step 2: Consultancy: Delphi process

• 20 patients who have experienced some form of counselling or CBT for tinnitus complaint (from an audiologist, hearing therapist, or clinical psychologist),

• 20 audiologists/hearing therapists who have received training in counselling or CBT and consult tinnitus patients.

The purpose of the Delphi survey will be to develop a consensus on what are the essential components and associated aims of tinnitus counselling from the shared perspective of the patient and the clinician.
Define problem

Recruit panel of experts

First round
open ended questionnaire

Second round
closed questionnaire

Third round
closed questionnaire with feedback

Final analysis

Which components of talking therapy do we incorporate into a manual?
Define problem

Recruit panel of experts

First round
open ended questionnaire

Second round
closed questionnaire

Third round
closed questionnaire with feedback

Final analysis

Patients and clinicians with experience of talking therapy
Define problem

Recruit panel of experts

First round
open ended questionnaire

Second round
closed questionnaire

Third round
closed questionnaire with feedback

Final analysis
Feasibility study

Outcome measures

**Feasibility**: recruitment, randomisation, compliance with manual, completeness of outcome measures (TFI, HUI3, EQ-5D, CORE-OM, CSRI - Client Service Receipt Inventory).

Secondary - semi-structured interviews to discuss their experience of the care, identify which components of the manualised care worked well, why, and which components are not useful, for a given patient.
Recruitment

Project launch early 2015

Year 1
Delphi review – consultation phase. Complete series of questionnaires, attend consensus meeting in Nottingham

- 20 clinicians, 20 patients

Year 2
Feasibility study – receive training in the manualised care and trial manualised care with five patients

- 3 sites – NHS Audiology Departments
Thank you

- Deb Hall, NIHR Nottingham Hearing Biomedical Research Unit
- Dawn Marie-Walker, University of Southampton
- David Stockdale, British Tinnitus Association
- Debbie Featherstone, Clitheroe Clinic
- Amanda Casey, Aston University
- Mary McMurrnan, University of Nottingham

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