AVAA Amplifier

Spring 2021

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Special points of interest:

- President's Message
- Implementation of Cognitive Screenings
- Mental Health and Tinnitus
- PTM
- AVAA Update
- Pets of AVAA

President's Message by David Jedlicka, Au.D.

As audiologists, we are well aware that May is "Better Hearing Month". During this month you will see the American Academy of Audiology, ASHA, and other professional organizations promote May is better hearing month across numerous platforms. One thing you may not know is that May is also "Mental Health Awareness Month".

In the last few years, there has been a push in audiology, like many other professions, to increase our involvement in interdisciplinary care. We are fortunate that the VA is a strong supporter of this model for many reasons. Research has shown that interdisciplinary care teams "decrease cost, improve patient satisfaction, and reduce morbidity and mortality through patient safety and error reduction". Additionally interdisciplinary healthcare teams will improve satisfaction in the workplace while strengthening professional relationships.

When we mention mental health and interdisciplinary care in relation to audiology, most of us will immediately think of Progressive Tinnitus Management (PTM). This treatment model includes audiologists, mental health providers, and most importantly the patient as part of the treatment team. Those of us working with tinnitus patients understand how important the mental health treatment component is to a successful outcome in this population.

It is in the best interest of our patients if we can expand our mental health considerations beyond patients suffering from tinnitus. It is well within our scope of practice to administer cognitive screenings and depression questionnaires. More importantly, it is our responsibility to ensure those identified as being at risk are referred to and contacted by the appropriate healthcare providers. This will ensure our patients receive the mental health care they need.

For those of you working with other professions to provide high-level mental health related interdisciplinary care, keep up the great work. For those of you who have not yet or want to get started, the time to do so is right now. There is no shame in cold-emailing people from the disciplines you want to work with to introduce yourself, provide education regarding audiology services, and to allow these other professionals teach you what they feel audiologists should know about their profession.

Finally, I hope all of you reading this will take a moment to put the Veteran's Crisis Line phone number in your cellphone and make sure it's easily accessible in your clinic. The number is **1-800-273-8255**. Veterans can also text **838255** to be connected with a trained responder.

Allen, D.D., Penn, M.A., & Nora, L.M. (2006) Interdisciplinary Healthcare Education: Fact or Fiction. *American Journal of Pharmacy Education.* 70(2): 39.

Implementing Cognitive Screenings in Daily Audiology Practice

Thanks for contributing, Aaron Roman, Au.D., from the West Chester VAMC.

Over the past decade or so, a body of studies have emerged exploring the relationship between hearing loss and cognitive impairment. The findings have been substantial, suggesting that hearing loss is associated with lower cognitive function, potentially due to increased cognitive load, higher rates of social isolation, and physiological changes in neurological functioning. Additionally, since most screening measures for cognitive functioning are conducted orally, evidence suggests that unidentified hearing impairment can lead to false diagnosis of cognitive impairment. It appears clear that hearing and cognitive functioning have a symbiotic relationship, and therefore must be considered together when we evaluate our patients, particularly those above 65 years of age, where the prevalence of mild cognitive impairment (MCI) is between 25% - 40%. As hearing loss is the second highest service-connected disability in the veteran population, and VA audiologists tend to work with older adult patients, cognitive impairment should be a major consider in everyday practice. In fact, ASHA classifies cognitive screening as a part of the scope of practice for audiologist. Yet, we as audiologists tend to be reluctant to screen for cognitive impairment as a part of daily practice. So, why should we screen for cognitive impairment? *S*

Screening for cognitive impairment is quick and easily integrated into patient interviews.

Some researchers suggest placing questions about cognitive status into the initial intake form as a possible "pre-screen". Such questions can focus on history of traumatic diseases, vascular disease, or depressive diseases (all potential causes of MCI). Other questions can be more cognitive-centric, such as:

- "Do you ever experience difficulty remembering certain words or events?"
- "Do you find it difficult to learn new things?"
- "Do you find it difficult to make decisions?"

These are just some examples that center around cognitive domains that could be impacted by MCI. Answering "yes" to any of the above questions could suggest that a more standardized screening measure may be needed to screen your patient. The good news is that most of these screeners are designed to be quick, averaging between 5 – 10 minutes.

Formal cognitive screeners are widely available and easily accessible.

There are many cognitive screening tests available that have been validated by independent research. These screening tests are usually delivered orally by a clinician and

assess the patient across a variety of cognitive domains, including (but not limited to) orientation, executive functioning, and information retrieval. Such tests include:

- General Practitioner Assessment of Cognition (GPCOG)
- Mini-Mental State Examination (MMSE)
- Mini-Cog
- Montreal Cognitive Assessment (MoCA)
- Saint Louis University Mental Status Examination (SLUMS)

Of these assessments, the MMSE and MoCA tend to be the most widely clinically implemented. The MoCA has a higher sensitivity in determining MCI compared to the MMSE, though it has some drawbacks for audiologists to consider. Of the tests listed above, the MoCA averages the longest administration time (10 minutes) and requires training before it can be administered and interpreted. Many employers will pay for the training, which can be completed over a few hours, so it is best to check with your practice before administering. The MoCA also has the benefit of having both a pencil and paper and digital administration method, which makes it a very versatile cognitive screening test. In other cases, the SLUMS is a strong, free alternative, and, according to some validation studies, is more sensitive to detecting MCI compared to the MMSE.

Screening for cognitive impairment can influence clinical testing and recommendations.

If you are considering implementing cognitive screening into your clinical practice and are uncomfortable interpreting the results, know that only a physician can deliver a diagnosis of cognitive impairment. Audiologists can, however, use the results from cognitive screening tests to alter their recommendations and testing protocols to suit the needs of the patient. Such alterations may include:

- Developing a referral system to specialists such as primary care providers, neurologists, and/or neuropsychologists in the event of a failed cognitive screening.
- Providing written instructions to test procedures and keeping the written instructions in the patient's line of sight throughout the testing process.
- Creating a reminder system for patients with hearing aids to regularly charge their hearing aids or replace their batteries.
- Working more closely with the patient's social circle to ensure adherence to hearing recommendations and decrease times of social isolation.

Given the close relationship between hearing and cognition, it is imperative that we as audiologists consider the implications of cognitive impairment on our daily practice. Through cognitive impairment screenings, we can better understand the needs of our patients and adjust our practice to be optimal for every patient, regardless of cognitive status. For a more comprehensive tutorial on implementing cognitive screening in your daily practice, I encourage you to read "Using Cognitive Screening Tests in Audiology" by Shen et al. (2016) published in the American Journal of Audiology.

Partnering with Mental Health to Treat Tinnitus

By Jeremy Joseph, Ph.D. & Leah Anderson, M.S.

Many providers in the VA quickly come to realize how common tinnitus is among Veterans seeking health care. While nearly 15% of the general public experiences some form of tinnitus, rates are much higher in Veterans. In fact, tinnitus is the top service-related disability among Veterans currently. Tinnitus is a serious health condition because the perception of loud sounds (when no external source of noise is present) can be distracting, disruptive, and highly upsetting. Further, the experience of "ringing in the ears" can be debilitating when it interferes with occupational tasks during the day and sleep at night. Problems related to tinnitus impact the patient as well as the people in their lives who witness this struggle.

Despite good medical advances in recent decades, we still lack a valid cure for many chronic health issues, including tinnitus. As a result, Veterans with tinnitus may feel upset, skeptical, helpless, or even angry when they come to VA providers for help and find that the best we can offer is symptom management. Emotional reactions from patients can also negatively impact providers because we care about our patients and try not to disappoint them. Fortunately, the treatment options available can significantly ease the symptoms of tinnitus and improve quality-of-life. Among these are a number of psychotherapies that will be described briefly below.

Before reviewing some of the psychotherapies designed to help patients better manage their tinnitus, it might be helpful to briefly look at the Veteran experience. Tinnitus is associated with hearing loss that can be acquired in a number of ways, such as age-related deterioration, exposure to loud sounds, head trauma, and traumatic brain injury—all of which active service members are exposed to at a much higher rate than the general population. Aside from the extreme noise of combat, where exposure to the roar of explosives and projectiles is common, many non-combat military settings are also quite loud. For example, service members may train in the field to get familiar with firearms or detonation devices, they could be assigned to aircraft or armored vehicles that lack sound insulation, or they might work in settings like repair shops and engine rooms that expose them to loud mechanical noises. If tinnitus is severe enough, it can abruptly cut short a career in the military and force service members into the Veteran role much sooner than they expected. Combat is a particularly harmful setting, as the noise of explosions is often accompanied by shock waves that can cause concussions. As a result, it is common to see patients in the VA who have acquired their tinnitus simultaneously with a host of other health issues (e.g., physical injury, traumatic brain injury, posttraumatic stress disorder). What this means for VA providers is that patients with a "simple" tinnitus complaint can be complex to treat because of related comorbidities that are also chronic in nature.

The Complimentary and Integrative Health initiative in the VA was created to address chronic health issues, like tinnitus. As they like to say, "Whole Health centers around *what matters to you*, not what is the matter with you." With discussion, educating, and coaching, Veterans learn to address the parts of their health they can change instead of dwelling on the areas that are outside anyone's control. In other words, while we wait for science to find a way to address the causes of tinnitus, patients can still learn how to relate to their tinnitus differently so that it becomes more manageable and less impactful. Some patients may balk at this and express the opinion that anything short of a complete cure is a waste of their time. Fortunately, many of these psychotherapies are simple to implement, enabling patients to quickly find that even incremental change in tinnitus can lead to meaningful improvements in mood, self-esteem, and social interactions.

Although tinnitus isn't a heavily researched area of psychology, various methods to improve symptom management have shown good efficacy. The primary evidence-based psychotherapies for tinnitus include: Cognitive Behavioral Therapy, Tinnitus Retraining Therapy, Mindfulness-Based Stress Reduction, and lastly Acceptance and Commitment Therapy. While each of these therapies takes a different approach, they share a common goal of shifting patient perceptions of tinnitus from dangerous and upsetting, to benign and manageable. Further, these therapies can be delivered individually or in groups, with group settings offering Veterans the opportunity to support and learn from each other, which fits well with the camaraderie of military culture.

Cognitive Behavioral Therapy (CBT) uses a range of techniques, including "Socratic questioning," to help patients match their level of reactivity to the actual severity of the problem. For example, if a patient always thinks of worst-case scenarios every time they experience tinnitus (e.g., "I'm broken and useless"), they may benefit from tuning into their self-talk and seeing how this thought could be causing more distress than the actual tinnitus. With some practice, patients can shift their self-talk to something more realistic and supportive (e.g., "Plenty of people with tinnitus still lead happy lives") which helps them build their ability to move forward with a sense of hope. Tinnitus Retraining Therapy (TRT) takes the basics of CBT and adds exposure to low level sounds to further help patients habituate to their symptoms.

Mindfulness-based Stress Reduction (MBSR) adopts a different approach by harnessing the power of meditation to disengage from reactions to unwanted or unpleasant stimuli. Instead of engaging in a debate with their self-talk, patients learn how to practice being in the present moment without judging or comparing their physical, sensory, and emotional experiences. For example, patients who practice seated meditation learn to recognize when they are engaging in thoughts that cause distress (e.g., "I can't stand this ringing in my ears") and then re-focus their attention on calmly breathing instead. Recognizing our thoughts as simply thoughts gives us the freedom to set them aside, rather than pursuing them any further.

Lastly, Acceptance and Commitment Therapy (ACT, pronounced 'act') combines aspects of MBSR with values clarification exercises to help patients regain a healthier and broader perspective. For example, patients may engage in an exercise to help them imagine how people will eulogize them after they pass away. Picturing a eulogy that begins, "She stopped doing all the things she really cared about in life to focus on fighting her tinnitus" sounds very different from, "Despite her tinnitus, she never stopped doing all the things she really cared about in life." An exploration like this can help empower patients to make room for their tinnitus symptoms in order to stay engaged in the activities that bring them a sense of accomplishment, happiness, and closeness. (con't page 6)

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Veterans with tinnitus often report frustration with the symptoms of tinnitus along with the additional burden of depression, insomnia, trauma, and headaches. Despite advancements in medical science, we still lack a cure. For patients and providers, the task of addressing tinnitus, can feel overwhelming or even dispiriting. Suggesting they try psychotherapy can be a tough sell because it isn't a cure and there is a fair amount of stigma around mental health in the Veteran community. However, providers can encourage patients in a few ways:

- Providers can remind patients that any relief, no matter the source, will be better than the current level of suffering. Using a technique like Motivational Interviewing, Veterans may realize they have nothing to lose if they give a psychotherapy a try.
- Providers can point to the pandemic as a timely example of another health issue impacting us all. Patients may agree that getting a dose of the vaccine has helped them regain a much-needed sense of normalcy, even if a cure is not yet available. Psychotherapies can therefore be framed as a type of "mental health vaccine."
- Providers can encourage patients to see psychotherapies as a place to learn tools for coping that will make them stronger and more resilient in general. Patients can use the skills they learn at any time without need of any equipment and there aren't any health risks or side effects

Empowering patients to be proactive with their health puts them back in the driver's seat and eases some of the expectations they place on their providers to have a fix for every problem.

Consult with your VA's Whole Health Outpatient team if you are interested in learning more.

Most VAs have a "Whole Health Consult" you can find in CPRS under "Integrative Health." If not, you can reach out to your clinic's general mental health clinic to learn more. If you can't find anyone locally to help, please feel free to contact the first author with any questions.

Resources

Moore, B. A., Moring, J. C., Hale, W. J., & Peterson, A. L. (2019). Incidence Rates of Tinnitus in Active Duty Military Service Members Between 2001 and 2015. *American journal of audiology*, *28*(4), 866–876. https://doi.org/10.1044/2019_AJA-19-0029

https://www.va.gov/WHOLEHEALTH/index.asp

https://mobile.va.gov/app/live-whole-health

https://www.ata.org/news/press-release/treating-and-curing-tinnitus-part-our-national-commitment-veterans

https://www.research.va.gov/topics/hearing.cfm

https://hearinghealthfoundation.org/veteran-statistics

The Intersection Between Tinnitus and Mental Health

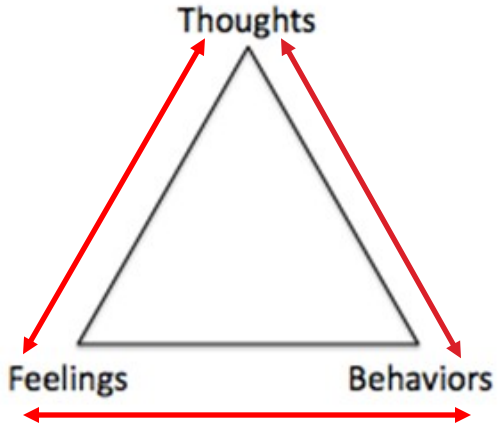
By: Alyssa Goldstein, Psy.D. & Lindsay Wakayama, Psy.D.

The VA has been a leader in delivering interdisciplinary treatments to patients with tinnitus. Partnerships between audiologists and mental health providers create opportunities to treat co-occurring mental health conditions. When compared to patients without tinnitus, those with tinnitus reported significantly higher rates of depression and anxiety, and lower rates of well-being and self-esteem (Krog, Engdahl, and Tambs, 2010). This article will discuss the role of psychologists in Progressive Tinnitus Management, as well as important psychological considerations when providing care to Veterans with tinnitus.

Though the prevalence of tinnitus increases with age, in a study of Veterans who served between 2002-2014, nearly 11 percent of Veterans age 26 and under with common post-deployment conditions were diagnosed with tinnitus (Swan et al., 2017). Younger Veterans who would benefit from hearing aids are often reluctant to use them. According to Ruusuvuori and colleagues (2019), working-aged individuals regard "hearing aid use as a negative appearance stigmatizing their identity" (p. 4). Psychologists are uniquely suited to decrease stigma and deliver Motivational Interviewing to increase adherence to Veterans' healthcare regimens. It is helpful to explore the perceived limitations of hearing aids, as well as potential benefits.

PTM Protocol from *How to Manage Your Tinnitus: A Step-by-Step Workbook*

Progressive Tinnitus Management (PTM) is a protocol developed by the National Center for Rehabilitative Auditory Research (NCRAR) at the VA Portland Health Care System. It has been widely disseminated within the VA and Department of Defense to effectively address and manage tinnitus. PTM uses principles from Cognitive Behavioral Therapy (CBT), an evidence based treatment that identifies and addresses unhelpful and interrelated thoughts, behaviors, and emotions.



What follows is an adjustable protocol outline, in which the number and content of sessions is subject to adaptation, based on individual patients' needs. For additional information resources, please visit: https://www.ncrar.research.va.gov/ClinicianResources/IndexPTM.asp.

1. Henry, J. A., PhD, Zaugg, T. L., AuD, Myers, P. J., PhD, & Smith, C. J., PhD. (2010). *How to Manage Your Tinnitus: A Step-by-Step Workbook* (Third ed.). San Diego,CA: Plural Publishing.

2. Krog, N. H., Engdahl, B. O., & Tambs, K. (2010). The association between tinnitus and mental health in a general population sample: results from the HUNT Study. *Journal of psychosomatic research*, *69*(3), 289-298.

3. Ruusuvuori, J. E., Aaltonen, T., Koskela, I., Ranta, J., Lonka, E., Salmenlinna, I., & Laakso, M. (2019). Studies on stigma regaring hearing impairment and hearing aid use among adults of working age: a scoping review. *Disability and Rehabilitation*, 1-11.

4. Swan, A. A., Nelson, J. T., Swiger, B., Jaramillo, C. A., Eapen, B. C., Packer, M., & Pugh, M. J. (2017). Prevalence of hearing loss and tinnitus in Iraq and Afghanistan veterans: A chronic effects of neurotrauma consortium study. *Hearing research*, *349*, 4-12.

5. VA.gov | Veterans Affairs. (2018). U.S. Department of Veterans Affairs National Center for Rehabilitative Auditory Research (NCRAR). Retrieved from: https://www.ncrar.research.va.gov/ClinicianResources/IndexPTM.asp

<table>
<tr><th>SESSION</th><th>CONTENT</th></tr>
<tr><td>ASSESSMENT</td><td>History of Presenting Problem (Tinnitus):
Location
Onset
Presumed precipitant
Exacerbated by
Relieved by
Functioning:
Other regular activities
Tinnitus prevents/interferes with
Coping strategies
Barriers to effective tinnitus management
Mental Health and Psychosocial History
Tinnitus and Hearing Survey</td></tr>
<tr><td>PSYCHOEDUCA-TION</td><td>Highlight: Tinnitus cannot be cured, but reactions to tinnitus can be managed
Goals of Tinnitus Management:
Reduce negative emotional reactions
Reduce stress
Limit attention on tinnitus
Decrease its negative impact on other activities of daily living
CBT Model: Thoughts, Behaviors, and Emotions</td></tr>
<tr><td>3-4. SOUND TYPES & PLAN</td><td>Types:
Soothing for Relaxation (Relief Scale), Background for Focus (Contrast Activity), Interesting for Distraction (Attention Scale)
Environmental, Music, Speech
Sound Grid Examples and Plan
<table>
<tr><th></th><th>Environmental</th><th>Music</th><th>Speech</th></tr>
<tr><td>Soothing</td><td>Nature sounds (ocean waves)</td><td>Classical</td><td>Imagery, Deep Breathing</td></tr>
<tr><td>Background</td><td>White Noise</td><td>Music w/ lyrics in a foreign music</td><td>Background TV/ Radio</td></tr>
<tr><td>Interesting</td><td>Animal Noises (Bird calls)</td><td>Song lyrics</td><td>Audiobook, Pod-cast</td></tr>
</table>
3 most Bothersome Sounds Worksheet</td></tr>
<tr><td>4-5. BEHAVIORS</td><td>Connection between stress and tinnitus
Behavioral Activation:
Relaxation: Deep Breathing and Imagery
Distraction: Pleasant Activity Planning</td></tr>
<tr><td>5-6. COGNITIONS</td><td>Awareness of Thoughts: 12 most common negative thoughts
Identifying Thoughts
Thought Record
Changing Thoughts and Feelings Worksheet</td></tr>
<tr><td>6+. REVIEW & MAINTENANCE</td><td>Review of Strategies: Sound Plan, Behavioral Activation, Challenging Thoughts
Identifying High Risk Situations (i.e., when Tinnitus is exacerbated) and Plan to Manage Tinnitus</td></tr>
</table>

AVAA BOARD UPDATES

- Want to see your pet in the newsletter? Email us to have your pet featured!
- Question, concerns, comments, or ideas for articles? Submit them to **AssnVAAuds@gmail.com**
- Its time to say goodbye to JR McCoy, Anna Black, and Jocelyn Sysko as they rotate off the board. We're sure to see great things from you guys in the future!
- Welcome to our new board members, Kaitlin Thoden, Michele Gortemaker, and Jessica Preston!

PETS OF AVAA

Who let the dogs out in this issue? We did! We are howling for joy over Dublin (left), the Bluetick Hound from Megan Sullivan at the South Hillsborough OPC. We love your patriotic pride, Graham Cracker (right) from Emily Seals at the Asheville VAMC.