TINNITUS MANAGEMENT

STRATEGIES FOR

HEARING HEALTHCARE

PROFESSIONALS©

A Practical Guide for the Clinical Professional

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PREFACE

This manual is dedicated to two exemplary educators/ audiologists:

• Professor Brad Allard, previously of Western Illinois University, Macomb, Illinois, who instilled the love of sound level measurement and analysis in particular, and industrial audiology in general.

• Professor Darrell Rose, previously of Northern Illinois University, DeKalb, Illinois, whose inspired and unusual teaching style helped develop a professional pride, and a lack of fear of treading anywhere audiological!

Additionally, the research, rehabilitation efforts, and concern of Dr. Jack Vernon for his tinnitus clients is noted, and has been a model and an inspiration for our profession to emulate.

The purpose of this manual is to provide the clinical audiologist, and other appropriate hearing healthcare specialists, with a practical guide to the management of tinnitus. The author has had involvement in this clinical activity over a period of 38 years, and has been a tinnitus sufferer (9,119Hz at 92dBSPL, to be exact) for 43 years! This publication is a synopsis of the techniques this author has found to be effective with tinnitus clients, and is not intended as a review of the literature available on tinnitus topics, or as a complete presentation of all tinnitus management topics.

TABLE OF CONTENTS

INTRODUCTION

Tinnitus can be defined as a subjective sound that is present in the ear or ears, or the head, when no sound is present in actuality (except in rare cases of objective tinnitus).

Historically, the term *tinnitus* has more than one pronunciation, and adherents of each are militant in their support of the term they have adopted; either is appropriate. The two most common pronunciations are:

1. 1TIN it es, and
2. tin EYE tes

Tinnitus may be perceived as a tone, a whistle, a hum, a buzz, or any other sound(s) of varying description. In this clinical experience of hundreds of clients, the vast majority of tinnitus descriptions are that of a tonal nature, with very few describing completely non-tonal tinnitus.

Tinnitus may be present all of the time, or it may be intermittent. Often, client description of intermittent tinnitus turns out to be constant tinnitus that is simply masked, in specific noise environments, to the degree that it is not perceived. A simple way of ascertaining this is to have the client use hearing protection in the environment where the tinnitus is not noted, thus determining whether or not it is still perceptible.

Tinnitus has many potential ramifications, with or without hearing loss, some of which may include:

1. it is an annoyance;

2. it can interfere with communication, masking or competing with the desired speech information;

3. it can interfere with going to sleep, or staying asleep;

4. it can be so prominent that it significantly changes the sufferer's lifestyle and personal interactions;

5. it can be so debilitating that the tinnitus sufferer may contemplate, or attempt, or commit suicide.

1Tinnitus has many potential causes, but the most common causes include:

1. Excessive exposure to intense noise.

2. Potentially ototoxic medications, including some commonly prescribed ones such as sleeping pills, antidepressants (**medications very frequently prescribed for tinnitus**), etc.

3. Head injury.

4. Other health complications or treatments such as tumors, allergies, viral infections, bacterial infections, elevated temperature, barotrauma, bruxism, middle ear disease, inner ear disease (such as Menieres disease), some genetic abnormalities, and treatments such as surgery, chemotherapy, radiation, etc.

A person's tinnitus, or perception of their tinnitus, can worsen by excessive or combined exposure to such agents as:

1. high intensity noise
2. negative emotional pressures/experiences
3. heavy physical exertion
4. some medications
5. caffeine
6. salt
7. allergens
8. other

These types of agents may become part of the tinnitus management program, and are detailed in the counseling and reporting sections of this manual.

It is the experience of this writer, over many decades, that the services provided to many tinnitus sufferers, by many health professionals, are often inadequate, and sometimes approaching the unethical. It is very common for a tinnitus client to mention that the family doctor, the otologist (ENT), the psychiatrist, the psychologist, and even sometimes the audiologist, to name a few, dismiss them with nothing more than the phrase "There is nothing I can do about your tinnitus; you will just have to learn to live with it." This generally is not a very accurate statement, however, and what the tinnitus sufferer requires is someone who can teach them how to "live with it". It is the opinion of this author, who may indeed be quite biased, that the audiologist is the person who, in most cases, is uniquely qualified to fill that role. Others hearing healthcare professionals may also play very important roles.