

The Clinician Managing Tinnitus Distress: A Preliminary Study in Clinical Engagement

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Abstract

Background: Tinnitus affects 10% of the population. It has been linked with depression, anxiety, insomnia and suicide. Because tinnitus is a symptom input from a multidisciplinary team of specialized clinicians is required and includes medical, allied health and mental health professionals. The study launched an enquiry into the knowledge, skills and attitudes of professionals dealing with clients with bothersome tinnitus.

Methods and Findings: Through an interpretive phenomenological lens, the life world of six participants, representing audiology (3), psychology (2) and otolaryngology (1) were chronicled. Participants were interviewed about their theoretical framework, the skills they employ, and the attitudes they bring to clinical encounters. The interview concluded with participants sharing a meaningful case. Data reached saturation and the analysis revealed four themes, centered on the value of connection, highlighting activities of reassurance and empowerment, while exposing clinician control and inter-professional criticism. The case studies appeared confessional.

Conclusions: The participants' decision to not put shine and polish on a difficult encounter, but to strip away the barriers of learnedness and competence to reveal the fear, vulnerability and genuine care underneath, is an honest barometer of the clinical landscape for these dedicated clinicians. The critical need for ongoing professional support to clinicians, and further research into the clinician experience were stated.

Keywords: tinnitus, clinical practice, counseling.

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INTRODUCTION

An integrated view of tinnitus management unequivocally supports a team approach¹. Tinnitus management is inherently multidisciplinary. Each of the professions has a different and non-replicated role to play in managing troubling tinnitus: to rule out underlying life-threatening medical conditions such as multiple sclerosis or acoustic neuroma (medical practitioners, specifically the primary care physician and otolaryngologist), alleviate communication difficulties by treating hearing loss (audiologist), or manage co-morbid psychological dimensions like depression and/or anxiety (counsellor/psychologist)².

Currently omitted from the larger discussion on tinnitus management, and directions of tinnitus research, is the professional's experience of treating tinnitus-related distress. A cursory acknowledgement of the knowledge and skill of the tinnitus clinician is intermittently offered, e.g. Baguley et al.: treatment should be situated within the expertise of an experienced professional with a deep understanding of all the different perspectives of tinnitus. Assuming certain literacy across disciplines, he further encourages a mutual regard and respect within the professional identities. The tinnitus clinician is therefore tasked with the integration of research and models into a Gestalt that is, according to Baguley et al. "congruent with personal clinical experience and understanding"³.

Baguley et al. acknowledge that some clinicians may feel daunted by what to do or say but insists that a prescriptive, cookbook approach would be neither helpful to the client nor the clinician. The current researcher concurs, but postulates that there should be a distinction of non-prescriptive and unexamined. Without an unravelling of the clinical reality of the tinnitus expert: what he or she thinks, says and implements within the specific professional scope that enables a distressed client to transform into a recovering person the deep understanding of the condition, and of the roles and responsibilities of the team remain incomplete. To date, the nature and essence of tinnitus management remain shrouded and restricted to experts.

Purpose and aims of the study

The purpose of the study is to generate knowledge about the knowledge, skills and attitudes of clinicians treating tinnitus and tinnitus-related distress and to explore the implications for clinicians who might encounter clients with tinnitus-related distress.

Researcher position

The researcher is a practicing audiologist, and counsellor experienced in tinnitus treatment. The current author is also engaged in ongoing clinical research in tinnitus management. During the study, her background and understanding of tinnitus from an audiological perspective is held consciously: her understanding of the neurophysiological model of tinnitus generation

and maintenance, which is considered the basis of audiological practice, and aspects of the use and benefit of hearing aids in the treatment of tinnitus in the presence of hearing loss.

METHODOLOGY

Research framework

An interpretive phenomenological analytical (IPA) framework is adopted in this study to achieve constellation of a rich and thick description of the participant experience by exploring the meanings attributed to particular experiences, situations and occurrences; how they made sense of their professional and personal world, and the experiences that shaped their professional persona. It is a collection of intensely personal accounts, which captures how people interpret and attach meaning to what they know, what they do and how they feel about it⁴.

Participants

Inclusion criteria

- An experienced tinnitus clinician, whom other clinicians would consider skilled in tinnitus management, and whom they would refer to.
- The clinician may be trained as a psychological, audiological or medical professional and registered as such a professional at the appropriate governance agencies.

Exclusion criteria

- A clinician who works for a manufacturer of tinnitus devices, or received commission from distributing tinnitus devices.

Sampling was purposive and identified potential participants who have experience treating clients who are distressed due to their tinnitus. Overall, eight potential participants were approached for recruitment into the study. Six participants, considered experts in their field in tinnitus treatment, were recruited and included:

1. An Ear, Nose and Throat specialist, with 25 years' experience in treating patients with a variety of otolaryngological complaints.
2. Three Audiologists, who are regarded tinnitus experts, were included:
 - Audiologist 1: Holds PhD, 30 years' experience as a clinician.
 - Audiologist 2: works in multidisciplinary private practice, with 10 years' experience, and sees a weekly caseload of tinnitus clients.
 - Audiologist 3: is an experienced clinician with 30 years of international experience.
3. Two clinical psychologists were included as participants:
 - Clinical psychologist 1: has over 30 years' experience,

and works from a Jungian psychoanalytic framework.

- Clinical psychologist 2: has over 10 years' experience, and works from a mindfulness and CBT framework.

Material and instruments

The interview was recorded via iPhone Voice Notes, following completion of the Informed Consent paperwork. The audio recording was supplemented with note-taking and memo-ing. All interviews were transcribed on a personal Apple MacBook Pro computer, and e-mailed to the participants for further comments or revision.

Data collection

The interview

- The interview included the following questions that were compiled by researcher based on her engagement with curriculum development for postgraduate training, and personal clinical experience in working with tinnitus clients. The questions were not pilot-tested prior to engaging with the first participant. The questions were:
- Could you share with me the theoretical framework you use when treating tinnitus and tinnitus-related distress. What has played a role in developing this framework?
- Think about what the approach and techniques you used with clients with tinnitus. What stands out in your mind?
- Do you have any specific thoughts or feeling about tinnitus? What has played a role in this experience?
- Finally, think about a case where tinnitus was involved - could you indicate what was helpful in your experiences?

Post interview

- Following the interview, a verbatim transcript was generated. Sections were re-storied where grammatical errors or phrases were obscuring understanding. The transcript was sent to each participant for comment and clarification.

Data analysis

Analytical strategy: All the interviews were read repeatedly to obtain a sense of the Gestalt, before breaking it into separate interviews (one per participant), and then into questions (across participants). Notes were written in the margins of transcripts to assist in the initial exploration of the dataset. Through this process, the larger organising themes emerged. From this organisation, initial categories were developed. The categories, also termed codes represent the heart of this particular interpretative phenomenological analysis as it builds the detailed descriptions, and the dimensions of the findings of the project from the data. Patterns within the codes, termed

themes, were generated from the analysis. Themes were identified, summarised and tabulated. Findings were contextualised within the literature framework and displayed as a table⁵.

Ethical considerations

The University of Notre Dame Australia Human Research Ethics Committee approved the study.

RESULTS

Data reached saturation across the first three questions of the interview schedule. As expected, the case study recollection revealed unique perspectives and clinical realities specific to each research participant. The research themes are summarised in Table 1.

Theme 1: The work is about human connection, not tinnitus

All participants utilise a discipline-mediated framework. The audiologists described the neurophysiological model of tinnitus, particularly the use of informational or directive counselling. Both the psychologists outlined a bio-psychosocial view of tinnitus, emphasising the role of the central neural pathways in modulating distress. The ENT used a differential diagnostic approach.

Certain sub-themes characterises the nature of the alliance between the participants and clients.

Sub-theme 1: Different framework, identical goal

Irrespective of professional approach, participants had a singular treatment goal: to establish and maintain rapport and trust with a client. Audiologist 1 states, "A lot of my effectiveness is to do with rapport and just the fact that they trust me. I think my skills and knowledge is unfortunately only second to that". Clinical psychologist 2 states, "You can have great content, and CBT structure, but there is no rapport, then intervention is going to fall flat. A really great alliance can carry a less skilfully applied intervention."

Sub-theme 2: Conditions

There were instances of clearly articulated

Table 1. Summary of research themes.

Theme	Subtheme
The work is about human connection, not tinnitus	Different framework, identical goal
	Conditions
	Apprehension
	Reassurance and Empowerment
The work is about holding anxious individuals	Listening
	Validation
	Plain speaking/Metaphors
	The approach
Clinicians direct management activity	The content
	The emphasis
Clinician Vulnerability	Criticism
	Revelation

expectations on client behaviour. Client obedience was linked to successful treatment outcomes because the client was perceived as “doing exactly what I told him to do. He has done fantastically, because he has done what I asked him” (Audiologist 3).

Another condition to establishing rapport is the clinician’s perception of the level of personal responsibility by the client, embodied in statements such as:

People really have to take responsibility for them as well. And the more they take that first step in trying to normalise their life, and taking on what you said about trying to use distraction, getting involved in other activities, the sooner they will feel better about themselves (Audiologist 3).

The final condition that emerged from one of the interviews is the relatively low level of tolerance for a client’s uncertainty with treatment effectiveness. Clinical psychologist 1 described how she approaches client scepticism:

If you feel that it is a waste of time, it is going to be. If you don’t want it, it is fine; I am not going to convince you about what you ought to have. It really does need a mature entry into treatment.

Sub-theme 3: Apprehension

Certain client groups were identified as presenting particular treatment challenges to participants. For Audiologist 1, it was middle-aged men, as she experienced instances where they tended to minimize the impact of tinnitus on their life. For Clinical psychologist 1 and Audiologist 3 described apprehension with younger males.

Because a lot of them would be young men who are not open to what I am telling them. I actually can’t treat them because whatever I suggest and how I explain...I’ll say to them: Can you see yourself doing this? And they say: No, I can’t do that (Audiologist 3).

Theme 2: The work is about holding anxious individuals in a safe place

While all the participants acknowledged their approach, and profession specific skills, such as making a diagnosis (The ENT surgeon), or deciding whether the client is a candidate for a hearing based management (Audiologist 1, 2 and 3), or psychological intervention (Clinical psychologist 2), all of the participants were uniform in what they come across daily: they are, without exception, encountering distress in a client. The focus is on reassuring the client by either dispelling myths clients have collected along the way or assuaging fears surrounding the significance and implication of a chronic tinnitus state.

Sub-theme 1: Reassurance and empowerment

The ENT surgeon strikingly contextualises his role in the clinical encounter when he states: “Patients come

to doctors primarily for reassurance. We are not curers, we are healers and I believe that re-assurance is healing”. Audiologist 1 echoes his statement when she states:

I think people react well to the perception of us understanding it in depth. I think they feel comforted by the fact that someone seems to know. I think they respond well to being lead or having a bit of a coach.

For Clinical psychologist 2, empowerment of the client is central to his practice and engagement. He believes that an empowered client is active in the overall management process, and well on their way to self-management. The following statement contrasts an active role with a passive one:

We try to basically empower people to self-manage and to take an active role in their own self-management rather than outsourcing it to an expert saying: Here Doc, fix me” (Clinical psychologist 2).

Clinical psychologist 2 also elaborates on what an engaged tinnitus self-management would entail which includes acceptance of its presence, and the search for a new normal.

But if you can approach tinnitus in a helpful way, you can slowly turn the alarm bells off, you can slowly change the neural networks and you can restore it to a more normal or palatable functioning. The treatment is to help people manage the experience and have less distress associated with the disorders rather than get rid of it (Clinical psychologist 2).

The ENT surgeon echoes this sentiment and empathises with the clients under his care:

99.5% of the patients get told that there is nothing we can do for you, go out and live with it, and that is possibly the worst thing you can say to a tinnitus sufferer because it leaves them desperate, frustrated and hopeless and I think the important thing with tinnitus patients is twofold: 1) reassurance and 2) empowerment.

Subtheme 2: Building the problem narrative through listening

The micro-skill of listening emerged as the primary technique used in dealing with tinnitus distress. All participants participated in eliciting a detailed narrative around the tinnitus problem story. The ENT surgeon states: “I will spend a lot of time talking to the patient, the nature of the tinnitus and how severe it really is for them, and how they are coping and what strategies they have used in the past”.

Sub-theme 3: Validation of the client’s inherent strengths, experience and future.

The participants all described an ability to meet the client where he or she is, through the use of validation. Audiologist 2 revealed that many of her clients have worked out some strategies themselves, but haven’t been able to articulate them, and “once they come in and I have talked about it they say, oh yes, I do that and I do that”.

Audiologist 3 also outlined how she validates the client's experience:

And just to reassure them a lot because I will say to them: when you first get tinnitus, suddenly it throws you into a panic. And I say to them: It is very normal to feel like that (Audiologist 3).

Audiologist 1 describes how receptive clients can be to appropriate information, and how willing they become to part with some of their initial health seeking behaviours and treatments:

Even in the first appointment, people change the most because they don't necessarily expect a great deal". I am quite direct in the way I dismiss some of the charlatan miracle cures, I don't ever want the client to feel silly or rubbished.

Sub-theme 4: Plain speaking/Metaphors

One of the salient characteristics of reassurance and empowerment is the professionals' tendency to use everyday examples and metaphors to support a client understanding of certain tinnitus aspects. The ENT surgeon and two of the audiologists enlisted the use of metaphors to clarify pertinent aspects of their reassurance strategy:

- The watch:

You are wearing a watch. You were wearing a watch before I brought it to your attention. You haven't remembered it since you put it on and then I'll say: now you can actually feel the pressure of the watch around your wrist (Audiologist 2).

- The apartment:

What I say to them that it is similar to living on a busy street. You have a beautiful apartment overlooking the beach but it is in a busy road and people come over for dinner and say: how do you live with the noise, and you say: what noise? Because you have accustomed yourself to it. Then I go through the various mechanisms of how they can achieve that (The ENT surgeon).

When you live in the country and you're moving to the city, and you move next to the railway line. That first month you are going to hear the trains all the time. Eventually it fades away and you'll only really listen to it when someone comes over and says: God, how do you live with that noise? But by then you've gotten used to it (Audiologist 3).

Theme 3: Clinicians direct management activity

The entire professional encounter is directed by the professional and includes the approach, which typically confirms to a scope of practice, but also the content and emphasis of intervention.

Sub-theme 1: Approach

The medical encounter allows for a diagnostic impression to emerge and usually entails several

assessments completed during the appointment: a hearing assessment, validated tinnitus questionnaires, a full ENT examination and a possible imaging for asymmetrical findings. Information sharing includes provision of useful websites, devices that could assist such as tinnitus maskers or hearing aids, and he concluded that distressed clients are referred for psychological intervention.

The audiological approach revealed that decision making centered on whether tinnitus was accompanied by hearing loss in a client. If the cause of the tinnitus was associated with hearing loss, the management of the overall hearing profile, and not tinnitus per se were initiated. Any atypical presentations were mentioned to the client's general practitioner in order to initiate referrals to various specialities including otolaryngology and psychology.

Clinical psychologist 2 described a Cognitive Behavioural Therapy approach that focus on a central nervous system disorder. He also outlined a bio-psychosocial model, and emphasised the need for a strong therapeutic alliance, within the broader CBT and mindfulness umbrella.

"I use a broad cognitive behavioural therapy approach, similar to an approach to chronic pain. Which is looking at treating a central nervous system disorder rather than a specific structural disorder."

Sub-theme 2: The content

The audiological participants used specific tinnitus surveys, or assessment protocols to identify the client's distress levels. Clinical psychologist 2 described intervention that identify and treat aspects of emotional stress and disturbance, which manifest in thinking and behaviour.

Sub-theme 3: The emphasis

The audiological participants all commented on providing informational counselling, based on the neurophysiological model of tinnitus generation, in simplified terms. Clinical psychologist 1 described how her focus remained on the impact of tinnitus on the client's life, and that she found a multidisciplinary approach, particularly helpful in supporting successful outcomes.

My aim for analytical work that I use is aimed at alleviating the tinnitus, that's what the person has come to me for. You don't have to analyse absolutely everything, that sometimes what are particular meaningful events in a person's life can be amplified.

Theme 4: Clinician vulnerability

Vulnerability, a state of feeling or being open to injury and attack, emerged in two ways from the data: 1) A striking sense of professional isolation was evident throughout the interviews, and 2) Criticisms across disciplines, within disciplines, and also within the general clinical practice were pervasive.

Some of the criticisms are captured but this could not be considered an extensive representation of the data:

Psychologist criticisms of GPs

What I did with the medicos if they were messing with my clients, I would write them a letter referring to the articles on research and say: you need to know that this research is effective, you need to be aware of it and that there are treatments programmes.

So often people have had these unhelpful healthcare practitioner encounters where they had been punitive or dismissive, or have provided that kind of catastrophic interpretation but a lot of time people come away thinking: the doctor thinks this is all just in my head, and especially if they have been referred to me, they are thinking: why should I be at a psychologist, a shrink, are you telling me it is imagined and it is all just in my head? (Clinical psychologist 2)

Clinician criticisms of clinician

That could be like going to the ENT surgeon, or asking an audiologist to plug them up with a device that would just take it away, and I am not so familiar with what the outcome literature says for tinnitus, but certainly in chronic pain, the reliance on those passive therapies yields much worse outcomes than active therapies (Clinical psychologist 2).

There is a very poorly established network, it is not well publicised, and I am not sure that there are people who specialise in tinnitus, and I am not sure that these interest groups and the psychological wellness groups are available to people and I think there is an expense attached to it and there is a lot of scepticism and poor education (The ENT surgeon).

“I talk to them about the various quacks out there, the 2000 remedies that are out there, in the chemist and the shops for tinnitus, and most of them don’t work” (The ENT surgeon).

Audiologist criticisms of psychologists

“Well, the psychologists don’t know anything” (Audiologist 3).

Audiologist criticisms of ENTs

“So if they go to an ENT who says there’s nothing that they can do and then they go and try a miracle cure or two, which doesn’t actually work, it unfortunately deepens the helplessness” (Audiologist 1).

ENT criticisms of ENTs

The patients are not impressed with all these tests that they have had, and they are not impressed by all the investigations because it is: so what. So the MRI is normal, thank God that I don’t have a tumour, now what? So you have done all these fancy tests and they have had all the vestibular tests and I have been to the fancy rooms,

and you charge me \$1500 for a consult, now what do I do? (The ENT surgeon)

ENT criticisms of GPs

“Whereas if the GP is educated about tinnitus, perhaps they would be more willing to prescribe medication or to send them on to tinnitus groups or to psychologists” (The ENT surgeon).

Revelation

The case that lingers provided a snapshot of the professional lifeworld of the tinnitus clinician. It revealed thoughtful, caring individuals who carry a sense of responsibility to the client and their respective professions. The caring manifested differently between participants, as continued analysis (Audiologist 1), as parenting (Audiologist 3 and Clinical psychologist 1), or as detachment (Audiologist 2) (Table 2).

DISCUSSION

The study described a professional landscape occupied by dedicated professionals who, to the best of their training and knowledge, try to alleviate some of the physiological (ENT surgeon, and audiologists) and psychological (psychologists) consequences of tinnitus.

Knowledge

All of the participants operated from within a theoretical framework that adhered to a model of tinnitus pathogenesis that acknowledges a trigger event (situated in the auditory periphery or even located external to the client), modulated in the central nervous system, to become either inhibited or distressing. They acknowledged that the complexity of the condition requires theoretical grounding in a model of tinnitus generation and the likelihood of more than one profession’s input⁶.

Skills

The research further asked about the skills employed by expert clinicians in their clinical setting. Participants revealed that the majority of their time and skills were focussed on connecting (Theme 1), and holding distressed clients (Theme 2). The skill cited by all participants were listening which indicates that expertise within each professional role was not associated with any specific activity within the scope of practice, but rather in the professional’s ability to build rapport quickly and effectively.

The bond between a client and practitioner is termed the ‘therapeutic alliance’. A therapeutic alliance may be defined as “an active engagement of the patient and therapist, which occurs when trust is established between practitioner and client through collaboration, communication, therapist empathy and respect⁷.”

The notion of good patient rapport is currently entirely assumed but not explored in the tinnitus literature. The results show that, even though preliminary, that tinnitus treatment outcome is dependent on the quality

Table 2. Case revelation.

Professional stance	Case summary	Redefined professional stance
I CARE "I think basically that I care, and the reason I love audiology is because I care, so it is all about people."	Suicidal man, referred from an ENT with no hearing loss. Three sessions of counselling focusing on personality and problem solving skills. Follow up after 3 months, where no distress was reported. "He had been reading the Bible. I felt like I missed a really big part of someone's life because I didn't ask him about his spirituality. But I didn't know what I was doing."	I RUMINATE "Decision-making is the hardest part and to know where to lead people and ask them if there is something else to this. Are we talking about the things we need to talk about?" I feel on a case-by-case basis, I question myself. "
I ANALYSE "The first thing I do is I say to myself: what is causing this client's tinnitus? Maybe this is wrong but I think for many of those people, they tend to have psychological issues of sorts and that's why tinnitus is dominating their lives."	Client with distressing tinnitus, and no measured hearing difficulties. He attended two sessions and was perceived as resistant to all recommendations. "He wanted more than I could give him, In terms of management I failed, he was just a person who wasn't going to accept a lot of what I had to say; I think he wanted the cure."	I DETACH "When I perceive that that is happening with a client (psychological issues), I suggest they see a psychologist in pursuit of other strategies to help with their tinnitus. That's where I think I don't have the skills to manage them as clients. "
TOUGH LOVE "I find it hard to work with people that can't help themselves."	A patient who experienced acoustic shock more than once. Painful ears with roaring tinnitus and isolation from his life. "We used combination devices, CBT PowerPoint and had regular contact."	I COERCE "You have got to get them out of that mindset" "He is better because he has done what I asked him"
I HEAL "In a sense, patients come to doctors for reassurance. We are not curers, we are healers and reassurance is healing."	High functioning suicidal lawyer who suffered a massive brain infarct, with roaring tinnitus (105/117 on the TRQ). Discussion of all the options, reassurance that the patient would gain control, and that the symptoms would lessen.	I PASS IT ON "I talk to them with the students present, I like them to be in on it, I like them to understand what it is all about. I think it leaves a lasting impression on students. They learn by imitation and learn by emulating."
DON'T WASTE MY TIME If you are going to work with me, don't waste my time because I want to work with people who want to work.	A patient with diagnosed with panic disorder and a substantial history of clinical anxiety.	I JUDGE "Some tinnitus clients do want to be controlled by their tinnitus. And so it is like being sick, there are a lot of reinforcers. They will get sympathy from their doctors, they will get it from other psychs, they'll get it from OTs, and they will get it from everybody who doesn't know how to manage tinnitus.
IT IS A RELATIONSHIP You can have a really great alliance and that will carry the therapy even with a less skilfully applied intervention.	Tinnitus with psychological problems predating the tinnitus.	AN OPPORTUNITY FOR GROWTH "An opportunity for growth and self-actualisation that a major health challenge presents. They quite often take away some profound insights and grow parts of their personality or being, which were previously a bit underdeveloped or neglected.

of the collaborative and affective relationship between the professional and client.

Attitudes

Without exception, the professional attitude legitimised tinnitus suffering. Participants were confident about the contribution their respective profession makes to tinnitus treatment. They revealed an intellectual curiosity to stay abreast of the latest developments and mentioned attending continued professional development activities to ensure the best practice is provided to the clients in their care.

Two attitudinal dimensions deserve reflection. Firstly, most engagement was professional-driven, and

secondly, inter-professional criticism was rife. Leach (2005) warns that clinicians who are more comfortable in a parental role run the risk of compromising rapport. An encounter where the professional takes control and where the client is expected to follow orders is neither conducive to patient growth nor the development of good rapport. Analyses of the interviews revealed an intellectual understanding of the need and nature of multidisciplinary involvement. Concurrently, a striking and pervasive scepticism was chronicled, of the availability and impact other professions within their particular clinical reality⁸.

The case descriptions acted as psychological confessions of how the changing nature of the clinical encounter impacted the participants. Instances of

rumination, judgement, coercion, alongside more positive recollections of healing, growth and support were evident. In terms of the researcher's reflexivity, it is with a sense of unease that the lack of opportunities for processing client encounters were observed. The participants in the study are vulnerable due to a lack of multidisciplinary cohesion, resulting at its most benign is working in isolation, but in reality revealed a lashing out, indeed a projection on other professions, of discomfort. Rumination, judgement and interpersonal attribution (blame) are markers of anxiety and mental discomfort, and negative energy not being discharged effectively. Clinicians are working hard in the room and the red flags are already evident:

- What clinicians 'give' clients are care, wholly mediated by control.
- What clinicians 'give' colleagues is criticism, cloaked in plausible deniability through isolation.

Despite these red flags and concerns, it would seem that the ability to reassure, and validate a client's distress about tinnitus, yield remarkable successful treatment outcomes. The researcher was confronted by the content of the interviews, particularly explicit recollections of telling people what to do, conditions to acceptance, and explicit judgement. The sense of unease increased as the analysis deepened: it is easier to judge someone else's vulnerability from within the comfort of a researcher's framework, and armed with the wisdom of hindsight. Memo-ing and reflexivity revealed a researcher that, while maintaining a certain level of (her own) judgement, and conditional acceptance, acknowledges that the interviews are acts of bravery. The participants' decision to not put shine and polish on a difficult encounter, but to strip away

the barriers of learnedness and competence to reveal the fear, vulnerability and genuine care underneath, is an honest barometer of the clinical landscape for these dedicated clinicians.

CONCLUSION

The participants' decision to not put shine and polish on a difficult encounter, but to strip away the barriers of learnedness and competence to reveal the fear, vulnerability and genuine care underneath, is an honest barometer of the clinical landscape for these dedicated clinicians. The critical need for ongoing professional support to clinicians, and further research into the clinician experience were stated.

REFERENCES

1. Holmes S, Padgham ND. Ringing in the ears: Narrative review of tinnitus and its impact. *Biol Res Nurs*, 2011;13(1):97-108.
2. Andersson G. The role of psychology in managing tinnitus: A cognitive-behavioural approach. *Semin Hear*, 2001;22:65-76.
3. Baguley D, Andersson G, mcFerran D, McKenna L. *Tinnitus: A multidisciplinary approach*. John Wiley & Sons, Chichester, West Sussex, U.K, 2013;2.
4. Merriam SB. *Qualitative research: A guide to design and implementation*. San Francisco, CA: John-Wiley & Sons, Inc., 2009.
5. Creswell JW. *Qualitative inquiry & research design: Choosing among five approaches*. Thousand Oaks, CA: Sage, 2013;3.
6. McFerran DJ, Baguley DM. Is psychology really the best treatment for tinnitus? *Clin Otolaryngol*, 2008;34(2):99-101.
7. Cole MB, McLean V. Therapeutic relationships re-defined. *Occup Ther Ment Health*, 2003;19(2):33-56.
8. Leach MJ. Rapport: A key to treatment success. *Complement Ther Clin Pract*, 2005;11(4):262-265.