

Provisional programme

7-9 June 2017, Copenhagen, Denmark

	Wednesday 7th June 2017
Time	Topic Presenter "Synopsis"
8:30-9:00	Registration & refreshments
9:00-11:00	Introduction to Cognitive Behavioural Therapy (CBT) in Tinnitus and Hyperacusis Rehabilitation Dr. Hashir Aazh, Head of Tinnitus & Hyperacusis Therapy Specialist Clinic, Royal Surrey County Hospital, Guildford <i>"This is an introductory and interactive session which gives an overview of specialist cognitive behavioural therapy focused on tinnitus and hyperacusis management and briefly discusses the limitations and evidence-base for this method."</i>
11:00-11:30	Break
11:30-13:00	Audiologist-led specialised CBT in Tinnitus and Hyperacusis Rehabilitation Dr. Hashir Aazh, Head of Tinnitus & Hyperacusis Therapy Specialist Clinic, Royal Surrey County Hospital, Guildford <i>"This is an interactive session which gives an overview of the specific interventions used in audiologist-led specialised CBT for tinnitus and hyperacusis. These comprise: (1) Establish relationship using client-centred counselling skills, (2) Enhance patient's motivation for CBT, (3) Formulation: Guided discovery, (4) Sharing formulation, (5) Agenda setting, (6) Goal setting and prioritising, (7) Check patient's mood and symptoms, (8) DTF as an assignment for identification of thoughts, (9) DTF as an assignment for challenging thoughts, (10) ABC (non-related to tinnitus/hyperacusis) assignment, (11) Reviewing DTF for identification of thoughts, (12) Reviewing DTF for challenging thoughts, (13) Creating counter-statements, (14) Psycho-education: ABC presentation, (15) Psycho-education: hearing-related information, (16) Psycho-education: cognitive distortions presentation, (17) Behavioural experiment: identify thoughts, (18) Behavioural experiments: challenging thoughts, (19) Socratic questioning to explore different way of thinking, (20) Discuss progress of therapy and termination."</i>
13:00-14:00	Lunch
14:00-15:00	Noise Exposure, Hyperacusis and Tinnitus Jos J. Eggermont, Professor Emeritus of Psychology and Physiology & Pharmacology, University of Calgary (Canada) <i>"Hyperacusis, the abnormally large loudness rating of sound, can result from two basic processes. The first is a bottom-up one in which the neural representation of sound is amplified in the various stages of the auditory pathway. The second is an abnormal interpretation in non-auditory structures downstream from auditory cortex, which still shows a normal neural representation. Reports suggest that this can happen in the insular cortex. The bottom-up process is often initiated by hearing loss, which is frequently induced by noise exposure. Not only traumatic noise can induce gain changes. Long exposure to moderate level noise (<70 dBA), either continuous or with interruption (12h:12h), and not causing hearing loss, changes in otoacoustic emissions, and ABR, do result in neural gain changes. These changes are a reduction in gain for neurons tuned to the frequency range of the exposure, and an increase in gain for neurons below and above this frequency range. The gain changes are accompanied by correlated changes in spontaneous firing, and potentially tinnitus. The induced changes in the auditory cortex of such exposures for about two weeks or more take several months to recover. This points to potential risk of working or living in certain noisy environments. I will describe the type of sounds that induce these changes and explore whether there are safe levels and durations of exposure."</i>
15:00-15:30	Break
15:30-16:30	Syndromic Tinnitus Mr. Don McFerran, Consultant Ear, Nose and Throat Surgeon, Colchester Hospital University NHS Foundation Trust, Colchester, Essex <i>"This lecture reviews Syndromic tinnitus and evidence-base for various medical treatments. Most cases of tinnitus are associated with pathological changes within the temporal bone, though for most people this pathology is simply the wear and tear of presbycusis or noise induced hearing loss. There are, however, some examples of tinnitus that are associated with particular medical syndromes. Examples that commonly include tinnitus as a symptom and are characterised by conductive hearing loss include otosclerosis and chronic otitis media. There is good evidence of the tinnitus outcome after stapedectomy for otosclerosis and generally this seems helpful. There is less information regarding chronic otitis media. Syndromes that feature tinnitus and sensorineural hearing loss include Ménière's disease and vestibular schwannoma. Information regarding the tinnitus outcome after treatment of these conditions is sparse and where evidence is available it is generally disappointing. Rhythmical or pulsatile tinnitus can be divided into tinnitus that is synchronous with the heartbeat in which case a vascular aetiology is likely and tinnitus that is asynchronous with the heartbeat. In the latter case, muscular causes are likely, particularly myoclonus of the middle ear muscles; palatal myoclonus is a rarer example. A form of tinnitus can be generated by an abnormally open, or patulous, Eustachian tube. Temporomandibular joint dysfunction is sometimes seen in conjunction with tinnitus though whether this link is causal or coincidental remains contentious."</i>
16:30-17:00	Tinnitus/ Hyperacusis-related distress Dr. Hashir Aazh, Head of Tinnitus & Hyperacusis Therapy Specialist Clinic, Royal Surrey County Hospital, Guildford

	Thursday 8th June 2017
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9:00-11:00	<p>History Taking, Psychometric Assessment, and Service Development Hashir Aazh</p> <p><i>"By the end of this session participants will be able to take a clinical case history for their tinnitus patients. This talk focuses on reviewing the clinical application of a wide range of self-report questionnaires in assessment of tinnitus handicap, self-report tinnitus loudness, annoyance and effect on life, severity of insomnia, and symptoms of anxiety and depression. In addition, by the end of this session, participants should be able to select and apply a wide range of specialist self-report tools for screening of underlying panic disorder, phobia, obsessive compulsive disorder, generalised anxiety, suicidal ideations, health anxiety and depression and make appropriate onward referral to mental health services for further investigations and treatment. This presentation reviews policies, protocols, audit tools, risk management, additional training, report writing, and other relevant topics to management of a tinnitus and hyperacusis rehabilitation service."</i></p>
11:00-11:30	Break
11:30-13:00	<p>Explore and enhance patient's motivation for CBT Hashir Aazh</p> <p><i>"This practical session provides an opportunity for participants to practice principles of motivational interviewing (MI; Miller 1996; Miller 1983) in the context of tinnitus and hyperacusis rehabilitation. MI is "a collaborative conversation style for strengthening a person's own motivation and commitment to change"(Miller & Rollnick 2012, p.12). MI is rooted in the client-centred counselling method of Carl Rogers (Rogers 1959) and gives great importance to understanding of patient's internal frame of mind and exhibiting unconditional positive regard (Miller & Rose 2009). However, unlike Rogerian client-centred style where the counsellor follows the patient's lead in a truly non-directive form, MI applies a guiding style of counselling where direction of the session is influenced by both patient and therapist in a collaborative way (Miller & Rollnick 2012). In MI it is important to encourage the patient to explore and verbalise their own reasons to change an attitude (e.g., accepting tinnitus) or the need to take an action (e.g., committing to a therapy programme which doesn't cure tinnitus but would help in management of the symptoms), as opposed to lecturing and giving them information and advice about benefits of CBT, or arguing about the negative consequences of doing nothing (Miller & Rollnick 2002)."</i></p>
13:00-14:00	Lunch
14:00-15:00	<p>Overview of CBT: application and principles of Diary of Thoughts and Feelings (DTF) and Guided Discovery Hashir Aazh</p> <p><i>"CBT is a psychological intervention that aims to help the patient to modify their unhelpful, erroneous cognitions and safety-seeking behaviours (Beck, 1976; Clark et al, 1999). The CBT approach is collaborative, with a strong emphasis on the clinician and patient working on a problem together. One goal is to test reality through 'collaborative empiricism', whereby the clinician and patient work together to test a range of hypotheses. Throughout, the principle of guided discovery is employed, in that the patient makes discoveries with some guidance from the clinician rather than the clinician pointing out maladaptive behaviour or errors in thinking. CBT involves helping the patient to identify, challenge and modify their unhelpful thoughts in response to tinnitus or environmental sounds. By the end of this practical session, participants should be able to use DTF for identification of tinnitus/hyperacusis-related events, thoughts and emotions. Principles of guided discovery and Socratic questioning will be used in order to explore patient's thoughts about the effects of tinnitus/hyperacusis on their life."</i></p>
15:00-15:30	Break
15:30-17:00	<p>Establish relationship using Client-Centred Counselling Skills Hashir Aazh</p> <p><i>"By the end of this practical session participants should be able to demonstrate an understanding of the theoretical and empirical underpinnings of client-centred counselling model of Carl Rogers. To apply a wide range of basic counselling skills within a clinical context for patients experiencing troublesome tinnitus and hyperacusis. Client-centred counselling was developed by Carl Rogers and emphasises on respecting and trusting the patient's capacity for growth, development and creativity (Rogers 1951). According to Carl Rogers, a non-authoritarian and non-directive approach by the clinician which encompasses the core counselling conditions facilitates the change process. The core conditions of client-centred counselling comprise: (1) the therapist is congruent in the relationship (In client-centred counselling, congruence means realness in a way that the counsellor is willing to be who he is), (2) the therapist is experiencing unconditional positive regard towards the client, and (3) the therapist experiences an empathic understanding of the patient's internal frame of mind (Rogers 1951; Merry 2002). A wide range of counselling micro-skills will be used throughout the process in order to (1) help the patient in establishing priorities and developing action plans, (2) explore various options and strategies as well as understand barriers and facilitators to change, and (3) improve confidence and helping the patient to mobilise their resources and develop an achievable timetable (Egan 2013; Egan & Thompson 1975). A summary of the micro-skills used in client-centred counselling comprise: open-ended questions, silence, focusing, empathy, paraphrasing, reflecting meaning, reflecting feelings, structuring, summarising, recognising patterns & themes, self-disclosure, immediacy, challenging, timing & pacing, goal setting, decision making, and problem solving (Egan 2013; Egan & Thompson 1975; Jenkins et al. 2000)."</i></p>

	Friday 9th June 2017
Time	Topic Presenter(s) "Synopsis"
9:00-10:00	Teaching patients to identify automatic thoughts and distinguish them from emotions Hashir Aazh <i>"By the end of this session, participants should be able to explain the CBT model and its relevance to tinnitus/hyperacusis. They should be able to use the ABC presentation to assist patients to learn how to distinguish between events, thoughts and emotions. In this session participants will be provided with a counseling tool that can help them in offering an overview of the ABC model of human mental disturbance to their patient. In ABC model, A represents activating events, B underlying thoughts, and C emotional and behavioral consequences to their patients (Ellis 1962; Beck 1976). Patient will be encouraged to think about various ABC combinations and to decide whether CBT would be beneficial for them or not."</i>
10:00- 11:00	Case conceptualization (formulation) and treatment Hashir Aazh <i>"By the end of this session, participants should be able to develop a CBT formulation explaining the development and maintenance of troublesome tinnitus or hyperacusis."</i>
11:00-11:30	Break
11:30-13:00	Identifying and modifying automatic thoughts: Application of Socratic questioning and other CBT techniques Hashir Aazh <i>"By the end of this session, participants should be able to use the cognitive distortions presentation and Socratic questioning in order to help their patients to explore different way of thinking."</i>
13:00	Group Photo
13:00-14:00	Lunch
14:00-15:00	Behavioural Experiments in management of tinnitus Hashir Aazh <i>"In CBT, behavioural experiments are defined as planned experiential activities undertaken by patients which are designed directly from a cognitive formulation of a problem and are aimed to (1) test the validity of patients' existing beliefs, (2) construct more adaptive beliefs, and (3) contribute to development and verification of cognitive formulation (Bennett-Levy et al. 2004). Behavioural experiments in the context of CBT are different from approaches which are rooted from behaviour psychotherapy (i.e., Tinnitus/Hyperacusis Retraining Therapy (TRT; Jastreboff & Jastreboff 2014) which aim to facilitate habituation through gradual, repeated, and prolonged exposure to feared stimulus. The main aim of behavioural experiments is to change perspective. If the troublesome thought and safety behaviours are accurately captured and examined in the experiment, then the change is likely to happen even after one single key behavioural experiment."</i>
15:00-15:30	Break
15:30-17:00	How to design suitable behavioural experiments in management of hyperacusis in children and adults Hashir Aazh <i>"This practical session focuses on the design and delivery of behavioural experiments in an audiologist-led Tinnitus and Hyperacusis Rehabilitation service."</i>