An Antigone of Tinnitus Care through a Kierkegaardian Lens

Risk-averse institutions maintain an ambiguous silence on cognitive behavioural therapy to treat tinnitus. This adds to a complex moral landscape for the lone audiologist, who is offered some ethical steering from Dr. Hashir Aazh, Director of the Hashir International Institute and President of the 4th World Tinnitus Congress.

The ethical boundary between audiological support, aural rehabilitation, and psychiatric treatment is a critical concern for audiologists treating tinnitus, particularly those trained in cognitive behavioural therapy (CBT).

In clinical practice, three broad positions can be identified. First, some audiologists show little recognition of the mental health needs of patients with tinnitus. Their focus tends to remain on hearing-related issues or sound management, often overlooking the psychological impact of tinnitus or the possibility of comorbid conditions such as anxiety, depression, or trauma-related disorders.

Second, other professionals, including some audiologists and many psychologists, acknowledge the psychological dimension of tinnitus but maintain that mental health care should be provided exclusively by psychologists. This position reflects concerns about professional boundaries, but also a lack of confidence in the adequacy of CBT training undertaken by audiologists. Some psychologists question whether audiologists, even those with additional qualifications, are equipped to deliver CBT with the depth and clinical insight expected within psychological professions.

Third, a growing group of audiologists recognises the psychological burden of tinnitus and chooses to acquire further training in CBT in order to provide structured, evidence-based interventions. These clinicians develop skills to address tinnitus-related distress and learn to distinguish it from distress caused by other psychological, medical, or social issues. They refer appropriately for the latter and treat the former within the scope of their advanced audiological practice.

THE ETHICAL SPACE FOR AUDIOLOGISTS OFFERING CBT FOR TINNITUS

This brings us to the nature of the ethical boundary itself. Rather than being clearly defined, it occupies a space between professional regulation and ethical responsibility.

In jurisdictions where CBT is legally or culturally reserved for psychologists, audiologists with appropriate training may find themselves in a morally complex situation. They are equipped to provide care, yet constrained by institutional and regulatory frameworks.

Some psychologists question whether audiologists, even those with additional qualifications, are equipped to deliver CBT with the depth and clinical insight expected within psychological professions.

This is not an example of unethical practice, as some critics might suggest. It is a situation marked by competing ethical obligations. The audiologist in this position is not violating a boundary, but acting as a moral agent within a system that lacks clarity. Their primary motivation is to reduce patient suffering in contexts where existing mental health services may be inaccessible, unsuitable, or unavailable.

The philosopher **Søren Kierkegaard** explored ethical conflict

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Some audiologists show little recognition of the mental health needs of patients with tinnitus.

A modern digital image of philosopher Søren Kierkegaard, who appealed to Greek tragedies to provide a framework for ethical conflicts: the audiologist providing CBT for tinnitus distress faces a similar dilemma to that fielded by the classical tragic hero Antigone.

MICAHRALEIGH, CCO, VIA WIKIMEDIA COMMONS

through the ancient tragedy of ***Antigone***. In Sophocles' play, Antigone defies the king's decree that her brother, Polynices, must not be buried because he is considered a traitor. She does not reject morality or authority outright. Rather, she chooses to follow a different moral imperative: loyalty to her family and respect for the dead. Her decision places her in direct conflict with civic law. The tragedy lies not in simple disobedience, but in the collision of two legitimate ethical demands. Antigone must choose between equally valid duties, and her suffering arises from the impossibility of fulfilling both.

The audiologist who offers CBT for tinnitus occupies a similar ethical space. This clinician does not reject professional standards or act carelessly. Instead, they are faced with a situation where strict adherence to one rule may conflict with core ethical commitments such as beneficence, non-maleficence, justice, and fidelity to the patient. In choosing to act, the audiologist is not violating ethics but responding to a complex moral landscape in which helping the patient requires thoughtful navigation of overlapping responsibilities. Like Antigone, their decision is not about choosing between right and wrong, but between two forms of right. This conflict can be further illuminated by W.D. Ross's concept of prima facie duties. The audiologist is faced with competing obligations: the duty to respect professional boundaries and the duty to alleviate patient suffering. When a patient is in distress and the audiologist has the competence to provide effective care, the ethical imperative to act may take precedence over the obligation to defer.

From a bioethical perspective, this decision is well supported.

Antigone, as depicted by Frederic Leighton.

PUBLIC DOMAIN

The principle of beneficence is clear. CBT is an evidence-based and recommended intervention for tinnitus-related distress, whether delivered by psychologists[1], audiologists[2], or through audiologist-guided internet-based self-help (iCBT)[3,4].

The principle of non-maleficence also supports action, as delaying or denying care due to inefficient referral pathways can unnecessarily prolong patient suffering. The principle of autonomy affirms the patient's right to receive care from the professional best positioned to help. Most patients do not view tinnitus as a psychological issue and are often unwilling to see a psychologist. Instead, they naturally turn to audiologists, whom they perceive as the appropriate point of contact.

TRAINING FOR TARGETED CBT METHODS AND TO ADDRESS A SPECIFIC PROBLEM

The principle of justice further strengthens this argument. Fair access to care must be upheld, even when psychologists are unavailable, lack training in tinnitus, or when patients do not follow through with referrals. These decisions are also supported by a virtue ethics framework, where moral qualities such as courage, practical wisdom, and compassion guide responsible action in situations marked by uncertainty or institutional silence.

For those who argue that CBT must be delivered exclusively by psychologists, the concern often centres on the belief that audiologists lack the depth and clinical context that comes with formal psychological training. This concern is understandable if one assumes that an audiology qualification alone is sufficient to deliver CBT. It is not. CBT requires additional, specialised training that lies outside the standard audiology curriculum. However, audiologists who choose to specialise in tinnitus frequently undertake focused CBT training designed to equip them to address tinnitus-related distress within a clearly defined scope of practice. This training is not as extensive as that undertaken by psychologists, who must be prepared to assess, diagnose, and treat a wide range of psychiatric disorders across diverse populations. Nor does it need to be. Audiologists are not treating psychosis, trauma, or personality disorders. They

are using targeted CBT methods to address a specific problem that falls within their domain of expertise.

Their training should reflect this scope. It must include an understanding of the psychological mechanisms that maintain tinnitus distress, supervised instruction in relevant CBT techniques, and the ability to identify when referral to mental health services is necessary.

Requiring audiologists to complete full mental health qualifications is disproportionate. It confuses the application of psychological methods with the diagnosis of psychiatric conditions, and it risks creating unnecessary barriers to care. It also delays access to effective treatment for patients whose distress may be severe and disabling, but who do not meet criteria for psychiatric intervention. A more proportionate and collaborative model recognises that multiple professions can use shared tools, provided they are trained appropriately and work within their competence.

Here, the moral tension is compounded by an ontological misunderstanding. Tinnitus distress is often treated as if it belongs within the domain of psychiatric disorders. This represents a category mistake. Although psychological processes are involved in how the condition is experienced and interpreted, the distress does not necessarily indicate psychopathology. Misclassifying tinnitus in this way gives rise to an epistemological error: the assumption that any intervention involving emotion or thought must fall exclusively within the remit of mental health professionals.

In reality, psychological strategies such as CBT are domain-general in nature. They can be applied to a wide range of non-psychiatric conditions by professionals who are appropriately trained in their use.

COURAGE AND TRUTH IN THE ABSENCE OF INSTITUTIONAL CLARITY ON CBT

Audiologists delivering CBT for tinnitus are not diagnosing or treating mental illness. Rather, they are using structured psychological techniques to address distress associated with a sensory-perceptual disruption, working within the boundaries of their training and scope of practice. Recognising this distinction is essential for ethical clarity and clinical accuracy. It also ensures that patients are not denied timely and appropriate care due to outdated assumptions about professional roles. In cases where tinnitus-related distress coexists with conditions such as anxiety or depression, a dual-pathway model offers an ideal approach. Audiologists address the tinnitus-specific elements of distress, while psychologists manage broader mental health concerns, ensuring comprehensive and collaborative care.

Institutional silence, however, creates uncertainty. Professional bodies often include tinnitus counselling within the scope of audiology but do not define what that counselling includes. CBT accreditation bodies neither endorse nor prohibit tinnitus-focused CBT delivered by non-psychologists. This lack of clarity leads to multiple interpretations. Some clinicians, trained in condition-specific CBT, see this silence as permissive and proceed ethically within structured models. Others interpret the ambiguity as restrictive. Institutions avoid risk by remaining vague, while clinicians bear the burden of interpretation and patients bear the burden of suffering.

> Their decision is not about choosing between right and wrong, but between two forms of right

The key ethical question is no longer whether audiologists *should* deliver CBT for tinnitus. It is whether institutions will acknowledge and support this practice with clear, proportionate guidance. In the absence of such leadership, individual clinicians are left to make these decisions alone. The audiologist who steps forward to deliver structured, evidence-based care is not abandoning ethics, but enacting its most important principles. They act with moral clarity in the face of institutional vagueness. Like Antigone, they uphold a higher duty in response to suffering that cannot be ignored. They are not tragic because they are misguided, but because the system does not yet recognise the legitimacy of their decision.

When rules are unclear and needs are urgent, ethical clarity becomes not only possible but essential. The care of people with tinnitus requires more than silence and neutrality from governing bodies. It requires courage, compassion, and a commitment to truth.

Dr. Hashir Aazh

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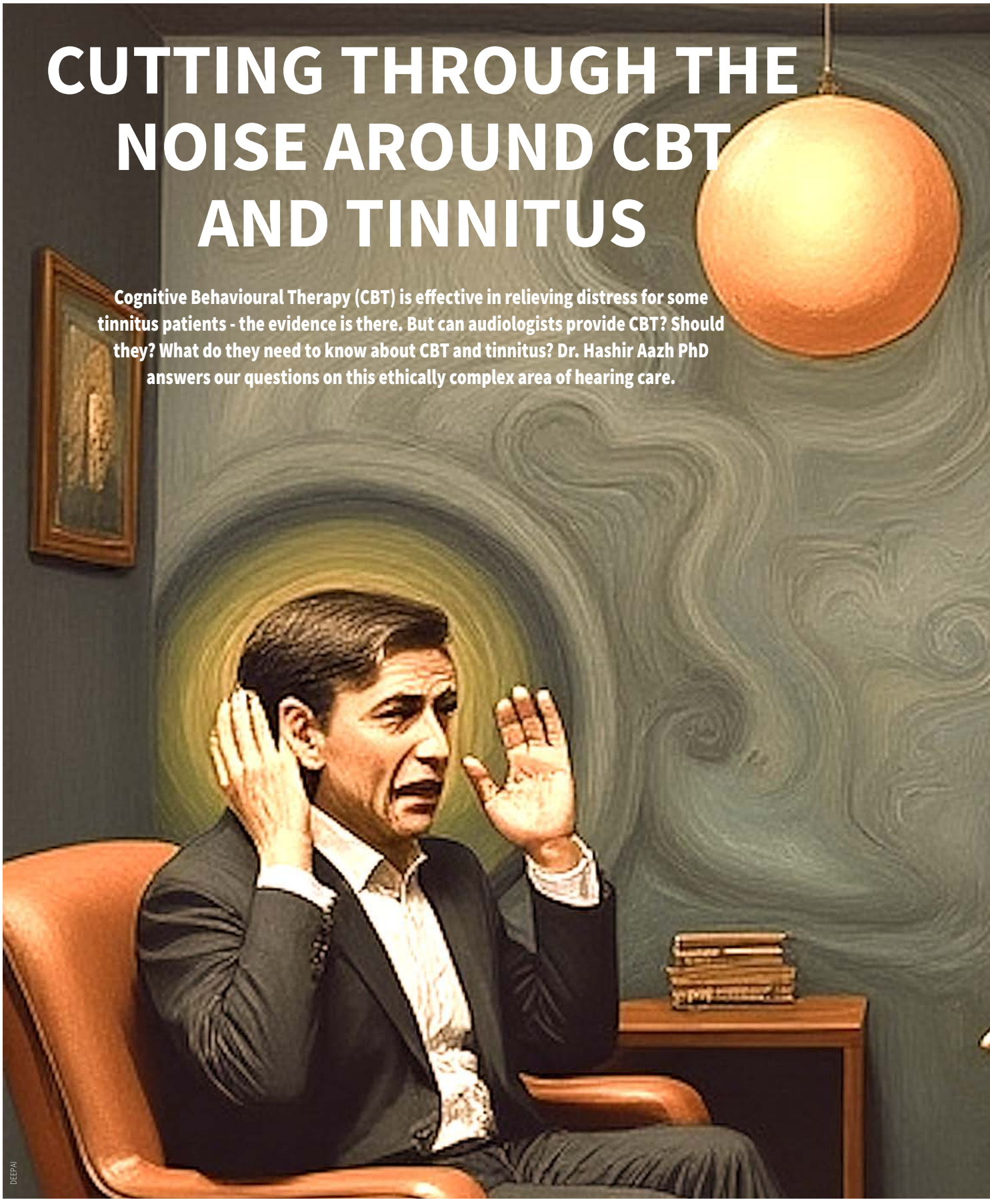
CUTTING THROUGH THE NOISE AROUND CBT AND TINNITUS

Cognitive Behavioural Therapy (CBT) is effective in relieving distress for some tinnitus patients - the evidence is there. But can audiologists provide CBT? Should they? What do they need to know about CBT and tinnitus? Dr. Hashir Aazh PhD answers our questions on this ethically complex area of hearing care.



Wide Angle

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Dr. Hashir Aazh: Refusing care on professional-identity grounds may do more harm than good.

Audiology News UK (ANUK): What is the current state of evidence supporting the use of CBT in tackling the impact of tinnitus?

Hashir Aazh (HA): CBT is widely supported as the most effective treatment for tinnitus-related distress. The evidence base for audiologist-delivered CBT is emerging and encouraging. Randomised controlled trials, patient-reported outcomes, and real-world studies show consistent improvements in tinnitus distress, and that both internet-based and face-to-face CBT significantly reduce tinnitus handicap and improve quality of life. While the field would benefit from more large-scale studies, current findings demonstrate both efficacy and strong patient support for receiving CBT from trained audiologists, and it has often outperformed standard counselling interventions.

ANUK: When is an audiologist prepared to provide CBT to tinnitus patients alone, i.e. without input from a psychologist?

HA: An audiologist is prepared to deliver CBT independently when the distress is specifically related to tinnitus, not indicative of broader psychological disorders. Using structured assessments and screening tools, they determine whether the patient's difficulties fall within their scope. When appropriately trained in tinnitus-focused CBT, audiologists can deliver therapy independently, referring patients to mental health services only when comorbid conditions are suspected.

ANUK: Just assessing a patient as appropriate for CBT requires an understanding of apparently intricate psychological aspects, such as acceptance, mood, negative thoughts or beliefs… Given the difficulty of these assessments, isn't the amount and type of training audiologists currently have to qualify them to provide CBT a focus for fair scrutiny of whether that training is sufficient?

HA: Yes, and scrutiny is appropriate—but should be proportionate. Audiologists do not require the same training as generalist mental health professionals, because tinnitus distress is distinct from psychiatric illness. What is needed is targeted training in condition-specific CBT, enabling audiologists to assess, treat, and refer appropriately. Overly broad training requirements misclassify the problem and create unnecessary barriers to care.

ANUK: What legal, ethical, ontological, and other pressures are audiologists under in relation to providing CBT?

HA: Audiologists face regulatory ambiguity, with unclear professional guidelines and no formal recognition from CBT accrediting bodies. Ethically, they confront the tension between protecting professional boundaries and meeting patient needs. Ontologically, tinnitus distress is often mischaracterised as mental illness. Epistemologically, their expertise in auditory-specific distress is undervalued. These pressures are compounded by professional silos and lack of institutional clarity.

ANUK: Faced by such pressures, how can the audiologist find the right mindset or framework in order to apply CBT without fear of what comes from kicking against the pricks?

HA: The audiologist can adopt a principled ethical framework that prioritises patient welfare, acting within a collaborative and supervised model. By viewing their role through the lens of moral responsibility—where the duty to reduce suffering takes precedence over rigid compliance—they can navigate the ethical tension with clarity, confidence, and integrity.

ANUK: If a therapy is effective by serving the intended end of restoring health, or bringing relief in the case of tinnitus, does this give audiologists a higher moral justification for pushing ahead despite the criticisms?

HA: Yes. When an intervention demonstrably reduces distress and is the only accessible or relevant form of care for the patient, delivering it is a morally justifiable act. Refusing care on professional-identity grounds, in such cases, may do more harm than good. The ethical imperative to alleviate suffering provides strong justification for continuing.

ANUK: We live in a world where ends justify such terrifying means; what thinking can underpin the goal of alleviating suffering as a higher end?

HA: Alleviating suffering becomes a defensible goal when rooted in compassion, professional responsibility, and clinical competence. Rather than utilitarian expedience, this approach is grounded in conscientious care, integrity, and fidelity to patient needs. It reflects ethical action not by bypassing rules but by engaging them critically in service of a greater moral good.

ANUK: In the specific case of applying CBT to tinnitus, how can audiologists feel sure they are not breaching scope?

HA: They can be confident by ensuring their practice is grounded in defined competencies, targeted training, structured assessment, and a clear referral protocol. They focus only on distress directly related to tinnitus, avoid treating psychiatric conditions, and make appropriate referrals when necessary. This demonstrates clinical responsibility, not overreach.