BEYOND FACTICITY:

Why Audiologist-Delivered Cognitive Behavioral Therapy (CBT) for Tinnitus Is an Ethical Choice

BY HASHIR AAZH

This article explores the ethical and philosophical case for audiologist-delivered cognitive behavioral therapy (CBT) in tinnitus care. Drawing on Sartre's and Merleau-Ponty's ideas, it argues that audiologists who pursue specialist CBT training act not outside their profession, but in authentic response to patient need, research evidence, and the silence of institutions.

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Introduction

Audiology, like every healthcare profession, is shaped by boundaries. We are trained within defined scopes of practice, certified by boards, and monitored by professional codes. These structures matter. They safeguard patients from poorly trained clinicians and maintain the integrity of our field. But they can also feel restrictive.

Few situations reveal this stress more sharply than the role of cognitive behavioral therapy (CBT) in tinnitus care. CBT is the only psychological intervention consistently recommended by evidence-based guidelines for tinnitus-related distress (Fuller et al., 2020; Martinez-Devesa et al., 2010). Yet audiologists, who spend their days in clinics with patients overwhelmed by tinnitus, often find themselves told, "You cannot do CBT. That belongs to psychology."

So, what exactly is meant by audiologist-delivered CBT? It is not a generic CBT borrowed extensively from psychology. Instead, it is a focused approach developed for the realities of clinical audiology (Aazh & Moore, 2018). From an ontological perspective, tinnitus-related distress arises from the lived experience of sound without an acoustic source. It is not, in itself, a psychiatric illness. The underlying mechanisms that generate tinnitus distress are likely to differ from those that give rise to conditions such as depression, psychosis, or trauma-related disorders, although the exact distinctions have not yet been completely established.

Epistemologically, this means we must approach tinnitus not as a symptom waiting to be classified under psychiatry, but as a phenomenon to be understood in its own right. Here, Merleau-Ponty's phenomenology of perception provides a useful frame (Merleau-Ponty, 1974). He argued that human experience is always embodied, situated, and mediated by meaning. Tinnitus distress exemplifies this: the sound itself is neutral, but once interpreted

> **Many patients with tinnitus do not see it as a mental health problem, rarely seek psychiatric help, and often find that mental health professionals lack specialist knowledge of the condition. Audiologists are the ones they often turn to, and CBT training allows audiologists to respond to that need.**

through memory, attention, emotion, and social context, it can become unbearable. This model recognizes that distress is not caused by sound alone but by how these internal sensations are interpreted, managed, and embedded in a person's wider emotional, physical, and social context. Many patients present with complex needs, including coexisting otological, medical, somatic, and psychological conditions (Genitsaridi et al., 2019). Addressing these needs effectively requires interdisciplinary insight, structured intervention, and clear professional boundaries.

Audiologist-delivered CBT is built around three core clinical components. The first is assessment, which involves developing a thorough understanding of the individual's needs. The second is patient education and holistic support, aimed at empowering patients through neurophysiological and psychologically informed education while incorporating multidisciplinary input when appropriate. The third is targeted CBT, which focuses on reducing sound-related distress, while ensuring that broader mental health needs are identified and referred to the appropriate professionals.

This distinction is critical. Audiologist-delivered CBT addresses the impact of auditory symptoms such as tinnitus, hyperacusis, or misophonia. Broader psychiatric comorbidities such as depression, trauma, and complex anxiety must be managed by mental health professionals using appropriate psychological and pharmacological approaches. Audiologists who deliver targeted CBT learn to distinguish distress directly linked to auditory symptoms from underlying psychopathology, apply focused CBT to the former, and facilitate referral for the latter. They do not provide CBT for issues unrelated to tinnitus or sound intolerance unless otherwise qualified, and they do not deliver CBT to patients with formal psychiatric comorbidities unless working within a multidisciplinary team.

Audiologist-delivered CBT does not compete with psychology, but complements it. Evidence already shows its effectiveness for tinnitus and hyperacusis, and implementing it is less a matter of overstepping professional boundaries than an ethical response to patient suffering.

Framed in this way, audiologist-delivered CBT is neither a dilution of psychology nor a case of overstepping professional boundaries. It is a targeted, symptom-focused intervention that complements, rather than replaces, the work of psychologists and psychiatrists. And it is here, within this carefully defined boundary, that the existential argument becomes pressing. Some still see it as stepping over the line. Yet from the perspective of philosophy, it looks less like a breach and more like an ethical act of responsibility.

Sartre and the Refusal of Facticity

Jean-Paul Sartre, the French existentialist, gave us the distinction between facticity and transcendence (Sartre, 1943). Facticity refers to all the givens of our situation: our professional title, the scope of practice documents, and the limits of our original training. Transcendence is our freedom to project ourselves beyond those limits, to imagine and enact new possibilities.

For Sartre, the danger is *mauvaise foi* (bad faith), collapsing into facticity and thereby denying one's freedom. When faced with a distressed tinnitus patient, many audiologists understandably say, "I am not a psychologist, so CBT is beyond my role." It is the cautious answer, and one shaped by the boundaries of our profession. Yet it also highlights a deeper ethical dilemma: do we stop at what our initial training permits, or do we explore responsible ways of expanding our skills to meet the patient's needs?

In contrast, the audiologist who recognizes tinnitus distress as human suffering that demands response, and then pursues additional training in CBT, embodies transcendence. They accept facticity (they are not a psychologist; their degree did not include CBT) but refuse to reduce themselves to it. They project beyond, reshaping their professional existence in fidelity to their patients.

Merleau-Ponty and the Traps of Empiricism and Idealism

Maurice Merleau-Ponty, the phenomenologist, warned against two traps: empiricism, which reduces truth to what can be most extensively measured, and idealism, which imagines neat solutions detached from lived reality (Merleau-Ponty, 1974). Both are alive in the debate over CBT for tinnitus.

The empiricist position says: the research base for audiologist-delivered CBT is smaller than that for psychologist-delivered CBT; therefore it is less valid. Yet this overlooks that the existing studies already demonstrate positive outcomes, and that patients' lived improvement cannot be erased simply because the dataset is thinner. Empiricism reduces the ethical decision to a numbers game.

The idealist position says psychologists should become experts in tinnitus, and patients should be motivated to see them. In theory, this seems tidy. In practice, patients do not perceive tinnitus as a mental health disorder, rarely seek psychiatric help, and psychologists are not routinely trained in auditory phenomena. Idealism imagines a world that does not align with the one we encounter daily in clinic.

Audiologists who pursue CBT training avoid both of these pitfalls. They do not remove their role on the grounds that fewer studies exist compared to psychologist-delivered CBT, nor do they wait for the ideal

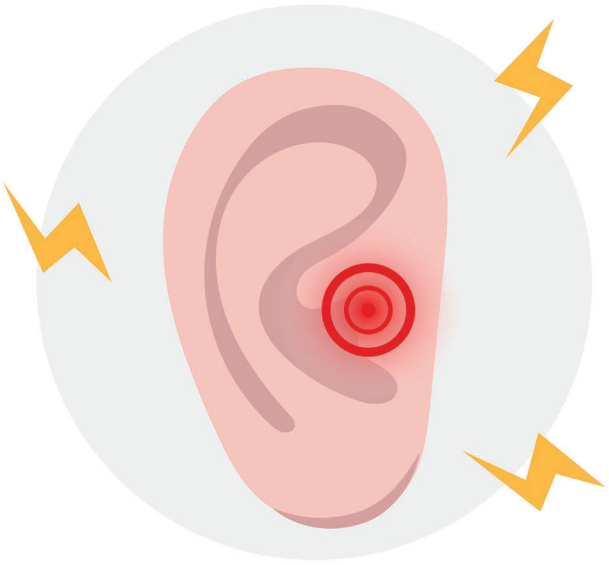
world in which psychologists suddenly become tinnitus experts and patients eagerly seek them out. Instead, they respond to the lived, embodied reality of patients who turn to them for help.

The Clinic as a Stage for Existential Choice

Of course, this all sounds lofty until we bring it down to the clinic. Picture a typical day. A 62-year-old patient sits across from you. His tinnitus is not the faint background hiss that many live with. It is intrusive, exhausting, and accompanied by sleepless nights and spirals of anxiety. You test his hearing, adjust his aids, and offer sound therapy. But his distress does not shift.

Do you say, "I am sorry, CBT is what helps here, but you will need to find a psychologist?" If you do, the reality is that the referral is very unlikely to be followed. Many patients do not believe that "talking to someone" will help because they do not consider tinnitus a psychological problem. They want a cure, not a referral, and some feel that being sent elsewhere means they are being passed along rather than supported. Even when they do comply, they often encounter psychologists who have little knowledge of tinnitus and who must prioritize conditions such as depression, obsessive–compulsive disorder, or schizophrenia. The chances of receiving an intervention focused specifically on tinnitus-related distress are therefore minimal.

In contrast, audiologists are uniquely positioned to bridge physiology, perception, and psychology. We can begin with the ear, explaining the neurophysiological model (Jastreboff & Hazell, 1993), which shows how negative emotional associations amplify tinnitus perception and prevent the natural



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process of habituation, and then connect this to cognitive theory (Beck et al., 1979), which describes the cognitive–behavioral processes that give rise to emotions and sustain distress. This framework allows us to deliver structured CBT tailored to tinnitus, while also ensuring that broader mental health needs are identified and referred appropriately.

Hence the moment of choice becomes clear. Do we turn the patient away with a referral that is unlikely to be effective, or do we equip ourselves with CBT skills to meet the suffering here, now, within the audiology clinic?

This is the existential moment. It is not about denying facticity, your current training, the scope documents, or the system. It is about refusing to let those define the whole of your professional being. It is about choosing transcendence, reciprocity, and authenticity.

Addressing the Critics

Now, critics will say, "But audiologists are not psychologists! CBT requires depth of training we cannot replicate." This objection has weight. Bad CBT, delivered without

proper preparation, can harm patients. The existential argument is not a license for recklessness.

But notice the structure of the objection. It assumes that the only alternatives are as follows:

1. Do CBT as a fully credentialed psychologist.
2. Do not do CBT at all.

Existential ethics suggests a third: pursue specialist CBT training as an audiologist, within a clearly defined scope. Not to treat psychosis, trauma, or severe depression, but to address tinnitus-related distress with structured, evidence-based methods. This is neither pretending to be a psychologist nor abdicating responsibility. It is inhabiting the space in between and making it real through training and practice.

The evidence itself, moreover, is steadily growing. A scoping review by Burke and El Refaie (2024) identified several studies supporting audiologist-delivered CBT, highlighting its safety, efficacy, and scalability. Randomized controlled trials led by Beukes et al. (2018) demonstrated that audiologist-guided, internet-based CBT significantly reduced tinnitus distress, insomnia, and negative thinking patterns, with improvements maintained at follow-up. Complementing this, clinical studies conducted in the United Kingdom by Aazh et al. (2019) within an audiology clinic found high levels of patient satisfaction. Median ratings were 8 out of 10 for effectiveness and 10 out of 10 for acceptability, with substantial improvements across tinnitus distress, hyperacusis, insomnia, anxiety, and depression.

In this context, the audiologist who pursues CBT training is not stepping into another profession's domain but responding to a genuine clinical and ethical need. Where institutions are silent, patients still speak, and it is to audiologists that they most often direct their voice.

Conclusion: The Ethics of Courage

Audiology is at a crossroads. Tinnitus and sound intolerance bring patients to us with problems that cross the border between ear and mind. Responding effectively requires courage: the courage to transcend narrow role definitions, to resist hiding behind professional anonymity, and to act in solidarity with those who suffer.

Audiologist-delivered CBT is not generic psychotherapy transplanted into audiology. It is not designed to treat psychosis, trauma, and complex psychiatric disorders, and there is no evidence that tinnitus-related distress requires the same type or depth of training as CBT for psychiatric illness. Instead, it is a structured, symptom-specific intervention that connects ear physiology with cognitive and emotional processes, addresses the particular distress linked to tinnitus and sound intolerance, and works in concert with rather than in competition with mental health care. This distinction is what grants it legitimacy within audiological practice.

The American Academy of Audiology (AAA) states that audiologists "assess, diagnose, and provide audiological treatment for persons with tinnitus using contemporary techniques that include, but are not limited to, biofeedback, tinnitus retraining, masking, hearing aids, education, and counseling (AAA, 2023, p. 3)."

Crucially, the AAA acknowledges that the field must evolve. It allows for individual specialization, noting that "by virtue of education, experience, and personal choice, some audiologists may choose to specialize in an area of practice not otherwise defined in this document," provided that the activity aligns with the AAA Code of Ethics. This position reflects a recognition that audiology, like all healthcare disciplines, must adapt to new knowledge, technologies, and patient needs.

For Sartre, the ethical danger is bad faith: hiding behind regulations or institutions to avoid responsibility. Merleau-Ponty reminds us that tinnitus distress cannot be reduced either to sound waves or to psychiatric categories. It is a lived, embodied reality, and responding to its demands requires an equally embodied and situated form of care. Within this evolving framework, audiologists are not simply allowed, but in some ways invited to adapt. The challenge is to do so with authenticity, responsibility, and courage.

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References

American Academy of Audiology. (2023). Scope of practice. Retrieved August 27, 2025, from https://www.audiology.org/wp-content/uploads/2023/04/Scope-of-Practice_2023.pdf

Aazh, H., Bryant, C., & Moore, B. C. J. (2019). Patients' perspectives about the acceptability and effectiveness of audiologist-delivered cognitive behavioral therapy for tinnitus and/or hyperacusis rehabilitation. *American Journal of Audiology, 28*(4), 973–985. https://doi.org/10.1044/2019_AJA-19-0045

Aazh, H., & Moore, B. C. J. (2018). Effectiveness of audiologist-delivered cognitive behavioral therapy for tinnitus and hyperacusis rehabilitation: Outcomes for patients treated in routine practice. *American Journal of Audiology, 27*(4), 547–558. https://doi.org/10.1044/2018_AJA-17-0096

Beck, A., Rush, J., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression* (1st ed.). The Guilford Press.

Beukes, E. W., Baguley, D. M., Allen, P. M., Manchaiah, V., & Andersson, G. (2018). Audiologist-guided internet-based cognitive behavior therapy for adults with tinnitus in the United Kingdom: A randomized controlled trial. *Ear and Hearing, 39*(3), 423–433. https://doi.org/10.1097/aud.0000000000000505

Burke, L. A., & El Refaie, A. (2024). The current state of evidence regarding audiologist-provided cognitive behavioural therapy for the management of tinnitus: A scoping review. *Audiology Research, 14*(3), 412–431. https://doi.org/10.3390/audiolres14030035

Fuller, T., Cima, R., Langguth, B., Mazurek, B., Vlaeyen, J. W., & Hoare, D. J., Cochrane ENT Group. (2020). Cognitive behavioural therapy for tinnitus. *Cochrane Database of Systematic Reviews, 2020*(1), Cd012614. https://doi.org/10.1002/14651858.CD012614.pub2

Genitsaridi, E., Partyka, M., Gallus, S., Lopez-Escamez, J. A., Schecklmann, M., … Hall, D. A. (2019). Standardised profiling for tinnitus research: The European School for Interdisciplinary Tinnitus Research Screening Questionnaire (ESIT-SQ). *Hearing Research, 377*, 353–359. https://doi.org/10.1016/j.heares.2019.02.017

Jastreboff, P. J., & Hazell, J. W. (1993). A neurophysiological approach to tinnitus: clinical implications. *British Journal of Audiology, 27*(1), 7–17. https://doi.org/10.3109/03005369309077884

Martinez-Devesa, P., Perera, R., Theodoulou, M., & Waddell, A., Cochrane ENT Group. (2010). Cognitive behavioural therapy for tinnitus. *Cochrane Database of Systematic Reviews, 8*(9), Cd005233. https://doi.org/10.1002/14651858.CD005233.pub3

Merleau-Ponty, M. (1974). *Phenomenology of perception*. Routledge & K. Paul; Humanities Press.

Sartre, J. (1943). *1958 being and nothingness* (H. E. Barnes, Trans.). Washington Square Press.