When Tests Are Clear but Suffering Persists: A Behavioral Extension of Care

Author: Scott Muenzler, ICF Certified Coach (ACC)

Behavioral coaching for chronic tinnitus and pain, adjunctive to medical and psychological care

Date: January 2, 2026

Contact for clinicians: Physicians@c3coaching.co

Where medical expertise and behavioral support work together to help patients recover.

Muenzler
TINNITUS COACHING

How This Paper May Be Relevant in Clinical Practice

• For clinicians seeing patients with persistent symptoms despite appropriate testing and reassurance

• Clarifies what behavioral coaching is and is not, and how it differs from medical care and psychotherapy

• Describes how coaching can support patients in translating medical reassurance into day-to-day functioning

• Outlines boundary-respectful ways coaching may complement existing care without adding clinical burden

• Intended as an orienting framework, not a treatment protocol or referral directive

A year before my tinnitus started, I had an experience that I recently realized has something to teach about persistent symptoms, including tinnitus.

I had been in agony for a week, hobbling on crutches because my left foot screamed at the slightest touch. NSAIDs hadn't helped at all. But now, sitting in the doctor's office, the moment of truth had arrived; all my test results, including an MRI, were ready. My anticipation quickly turned to fear and anger as the doctor walked me through the results and concluded:

"There's nothing to see in any of this… no bone or joint issues, no soft tissue damage. Whatever's going on, it's not showing up here. You should be fine."

I was furious more than anything else. I'd spent an entire workday having tests and waiting, only to be told there was *nothing there.* What happened next was something neither of us could have predicted, and I'll come back to it later.

I share that moment because it captures something described in the literature on persistent or medically unexplained symptoms: that uneasy space where reassurance doesn't reassure.[1,2]

Many clinicians report that some of the most challenging cases are those in which test results offer no clear or proportionate explanation for a patient's suffering.[3] Whether it's chronic pain, tinnitus, dizziness, or fatigue, many physicians describe the frustration of seeing symptoms persist long after reassurance, explanation, and appropriate medical management have done their part. These are the cases that linger because the suffering is visible, yet the toolkit grows thin once dangerous or explanatory pathology has been ruled out.

Behavioral coaching for chronic symptoms offers one way to close that gap. It's not a substitute for medical care or psychotherapy. It is a structured behavioral process that helps patients retrain attention, emotion, and behavior around chronic symptoms, and can meaningfully reduce symptom-related distress and improve functional outcomes in patients who have already undergone standard medical evaluation.[4,5] For physicians interested in the neurobiological rationale for that process, see Persistent Physical

Symptoms in Clinical Practice: A Descriptive Framework for Psychophysiologic Disorders (PPD).

What Coaching Adds to Clinical Care

Coaching uses goal-directed conversation methods informed by established behavioral frameworks to strengthen motivation, build self-efficacy, and support actionable change.[6] In practice, it gives patients the time and structure to translate what they intellectually understand ("My scans are fine") into what they can actually live ("I no longer react with fear when symptoms arise").

The effectiveness of this process reflects both the quality of the working relationship and the structure of the method itself. Meta-analytic evidence shows that the quality of the therapeutic alliance itself predicts outcomes across a wide range of psychotherapeutic approaches, highlighting the value of structured, empathic conversations even outside formal psychotherapy.[7] Coaching emphasizes collaborative, goal-aligned relationships that are associated with coaching effectiveness, while remaining distinct from psychotherapy.[6,8] Coaching provides structured follow-through, including explicit goal tracking, ongoing follow-up, and iterative adjustment, processes that have been associated with improved self-management and patient-important outcomes in chronic conditions.[6,9] In practice, meaningful progress requires both patient readiness for change and careful attention by the coach to scope and coordination with medical care.

In clinical settings, elements such as reassurance, motivational interviewing, or behavioral encouragement may already be used informally, and coaching builds on these conversations in a more structured way. It provides a framework for follow-through that can be difficult to sustain within time-limited clinical encounters: consistent accountability, iterative learning, and emotional normalization.

The coach's role is neither diagnostic nor interpretive. It focuses on behavioral translation, accompanying patients as they work to integrate medical information into daily life through approaches such as attention training, stress regulation, and graded engagement with feared sensations or situations. In this way, coaching can function as an adjunct to standard care in conditions where distress and attention appear to shape symptom experience, such as tinnitus, chronic pain, or medically unexplained symptoms.

The Mechanistic Overlap

From a neurobiological standpoint, coaching aligns closely with what modern neuroscience describes as predictive-processing models of perception. This framework parallels concepts already familiar in medicine, such as central sensitization in chronic pain or maladaptive conditioning in anxiety.

As Moseley and Vlaeyen described in their 'imprecision hypothesis' of chronic pain, distressing sensations can persist when imprecise threat-related learning is not corrected through stimulus differentiation and more precise encoding of relevant sensory information.[5] In this view, recovery depends less on eliminating signals than on retraining interpretation, and coaching can offer a structured context for this process through guided behavioral experimentation and reinterpretation in real-world settings.

In pain and related symptom research, perception is increasingly understood as an inference shaped by attention, emotion, and expectation rather than a direct reflection of sensory input.[10] Within predictive-processing models, fear is understood to bias perception toward threat, while corrective learning can, over time, reduce this bias.

Coaching in these contexts works on the same terrain, helping patients reinterpret bodily signals not only intellectually but experientially. Such processes are consistent with mechanisms described in exposure-based and self-efficacy–oriented interventions, including gradual reduction of threat responses and increased behavioral confidence.

This conceptual overlap offers one account of how coaching can complement medical reassurance in practice. Where medicine establishes medical safety, this behavioral approach operationalizes it. Through repetition and feedback, patients can learn that daily function and emotional safety can coexist with residual symptoms, as symptom intensity may lessen over time when perception becomes less threat weighted.

This framework provides one way of interpreting how behavioral approaches can be understood within predictive models of chronic symptoms across diverse patient populations.[11]

Evidence Relevant to Integration

Across chronic illness care, research spanning randomized trials, meta-analyses, and qualitative studies has examined behavioral and self-management interventions that emphasize self-efficacy, emotional regulation, and goal-directed behavior within routine medical contexts.

- **Health and Wellness Coaching Meta-analysis**
  In a meta-analysis of 30 randomized trials (8,662 participants), health and wellness coaching improved quality of life, self-efficacy, and depressive symptoms, all identified as patient-important outcomes in chronic illness care.[6]

- **Tinnitus-Specific Behavioral Intervention Evidence**
  In a randomized controlled trial, Cima et al. demonstrated that a structured cognitive behavioral intervention targeting maladaptive thoughts, emotional reactions, and behavioral responses to tinnitus significantly reduced tinnitus distress and improved quality of life.[4]

- **Structured Self-Management Interventions in Chronic Illness**
  Brief, structured self-management interventions emphasizing goal setting, action planning, and problem-solving skills have been shown to improve self-efficacy and functional outcomes in chronic illness, with authors explicitly emphasizing their feasibility and suitability for integration into routine primary care.[9] These same elements, including goal setting, action planning, and collaborative problem solving, are central to professional coaching and help explain why coaching-based approaches translate well to chronic illness care.

- **Chronic Disease Self-Management Compared With Usual Care**
  In a randomized controlled trial, participants in a chronic disease self-management program demonstrated greater improvements in functional status and self-efficacy than those receiving usual care, with reductions in pain also reported,

and the intervention explicitly framed as complementary to ongoing medical management.[12]

- **Client Agency and Collaborative Engagement**
  Qualitative research has examined how clients experience agency within psychotherapy, with collaboration discussed as an integral aspect of client participation, highlighting these processes as salient features of the therapeutic experience.[13] Because professional coaching is similarly structured around collaborative goal setting and client agency, these findings help clarify why coaching approaches are often experienced as complementary to medical care.

Taken together, these studies help clarify how coaching-aligned approaches fit within chronic illness care by reinforcing self-management capacities, fostering goal-directed behavior, and complementing ongoing medical treatment.

How Integration Works in Practice

After appropriate evaluation and reassurance, some patients continue to return with persistent concern or functional limitation despite stable findings. In these moments, a clinician might say something like:

"We've ruled out the things we worry about medically, and I'm comfortable with where things stand from a safety perspective. I also see that the symptoms are still taking up a lot of space in your day. There are professionals who focus specifically on helping people work with that part of the experience and how attention, fear, and daily responses interact with ongoing symptoms. This wouldn't replace your medical care, but it could support the next phase of coping and adjustment. If you're open to it, we can talk about that as an option."

In this framing, the medical work is clearly complete, responsibility for safety remains with the clinician, and coaching is introduced as an optional, adjunctive support focused on behavior and adaptation rather than diagnosis or treatment.

In clinical settings, coaching can be incorporated into existing care pathways without requiring major changes to established workflows. Implementation naturally depends on context, staffing, and patient load, but even small pilot collaborations can help clarify fit and workflow in ways that feel worthwhile to both clinicians and patients. In practice, integration may involve the following components. Rather than representing distinct pathways, these components often overlap in practice:

1. **Post-Consultation Referral and Parallel Coaching:**
   After diagnostic work-up and reassurance, physicians can refer patients who remain functionally limited or anxious to a coach experienced in chronic-symptom retraining who can help shift the focus from "Why do I still feel this?" to "How do I respond differently when I do?" For ongoing conditions such as tinnitus or chronic pain, coaching can run concurrently with standard care, with attention to patients' responses to symptoms, patterns of avoidance, and practical lifestyle adjustments.

2. **Flexible Delivery Formats**:
   While in-person sessions may be preferred by some patients, phone or video-

based sessions can be used for follow-up between appointments, particularly when travel or symptom burden makes in-person visits difficult.

3. **Optional Collaborative Feedback Loop:**
   With the client's explicit consent, coaches can share brief progress summaries with referring clinicians, tracking themes such as sleep, activity, and emotional resilience, so the medical team stays informed while the client's confidentiality and autonomy are fully respected.

These components shift the emphasis from reassurance alone toward skill development. Rather than hearing "There's nothing more we can do," patients hear, "You're safe, and now here's someone who can help you retrain the patterns keeping you stuck."

It is also important to note that this kind of behavioral support is not appropriate or acceptable for every patient. Readiness, tolerance, and expectations vary widely, and some individuals may find structured coaching unhelpful or burdensome, particularly early on. In practice, coaching is most often introduced selectively, after repeated reassurance and medical explanation have failed to reduce distress or functional limitation. For this reason, collaboration typically begins on a small scale, with individual referrals rather than broad implementation, allowing clinicians and patients to assess fit without pressure or obligation.

Clarifying the Roles of Medicine and Coaching

Medicine	Coaching
● Detects or rules out pathology	Guides patients in modifying responses once danger is excluded
● Provides reassurance ("You're safe") when appropriate	Helps patients translate reassurance into day-to-day behavior
● Prescribes treatment plans	Facilitates thoughtful decision-making, pacing, and behavioral follow-through
● Manages acute symptoms	Builds capacity for longer-term emotional and attentional regulation
● Defines clinical boundaries	Reinforces patient autonomy and competence
Together: Medicine establishes safety; coaching helps patients translate it into daily function.	

Ethical and Professional Boundaries

An important feature of coaching is its clear scope boundaries. Coaches do not diagnose, treat, or manage disease. When signs of psychiatric instability or medical red flags appear, referral back toward appropriate clinical evaluation or care is essential. This clarity helps reduce overlap while preserving collaboration.

In this sense, coaching parallels physical therapy: both are behavioral extensions of medical reasoning, focused on skill acquisition and gradual autonomy. The goal is not

dependence but competence: the ability to self-regulate and live fully even in the presence of persistent or fluctuating symptoms.

The Broader Value to Medicine

In an era of constrained appointment times and chronic patient overwhelm, coaching offers a practical structure for cultivating self-management and emotional regulation. It helps clinicians extend their impact beyond the visit, without extending their hours.

Integrating behavioral coaching within care teams can meaningfully improve clinical workflows and the patient experience without adding to clinicians' time burden.

Patients feel seen not only for their test results but for their lived experience. Clinicians, in turn, gain partners who help translate insight into sustained change.

Before closing, I want to return briefly to the clinical moment that opened this paper.

"So what happened with your foot?"

When I expressed my frustration, the doctor didn't seem to know what to say or do, other than to repeat what he'd already told me. But as he talked, I found myself thinking back to something that had happened eight years earlier, when I'd recovered from eighteen months of chronic testicular pain, after consulting dozens of physicians, doing countless tests, and trying a dizzying array of medications that never worked - all in just three weeks, and without surgery or drugs.

I told this doctor a brief version of that story. His response was immediate and decisive.

"Stand up."

As I did, he asked what I felt. To my astonishment, I felt *nothing.* He asked me to walk around the office, and I still felt nothing. Then he told me to go outside, walk around for five minutes, and come back. I did, and the pain was gone.

Whatever had been going on had vanished in an instant. It was as if all I had needed was for someone with expertise I trusted to tell me, unequivocally, that nothing was wrong. I went home both relieved and a little embarrassed. The pain never returned.

That experience taught me something essential: reassurance only works when it's *believed.* The doctor didn't use any psychological techniques; he simply embodied safety and certainty in a way that I could finally trust. That was enough to flip the switch from threat to calm.

In coaching for chronic symptoms, we work deliberately with that same process: helping people retrain their perception of danger, rebuild confidence in safety, and integrate what medical reassurance can't always achieve on its own.

An Invitation to Collaborate

If you're a clinician interested in exploring how coaching can complement your work, whether through patient referrals, joint case discussions, or research collaboration, I'd welcome a brief discussion about how this approach could help patients translate medical reassurance into lasting change.

Coaching cannot replace what you do. But when reassurance has done all it can, coaching often helps patients take the next steps: building on safety to restore confidence, and on confidence to create real, lasting change.

Contact:
Scott Muenzler, C³ Coaching
Physicians@c3coaching.co

References

1. Byrne AK, Scantlebury A, Jones K, Doherty L, Torgerson DJ. Communication interventions for medically unexplained symptom conditions in general practice: A systematic review and meta-analysis of randomised controlled trials. *PLoS One*. 2022;17(11):e0277538. doi:10.1371/journal.pone.0277538

2. Lehmann M, Pohontsch NJ, Zimmermann T, Scherer M, Löwe B. Diagnostic and treatment barriers to persistent somatic symptoms in primary care - representative survey with physicians. *BMC Fam Pract*. 2021;22(1):60. doi:10.1186/s12875-021-01397-w

3. Löwe B, Toussaint A, Rosmalen JGM, et al. Persistent physical symptoms: definition, genesis, and management. *Lancet*. 2024;403(10444):2649-2662. doi:10.1016/S0140-6736(24)00623-8

4. Cima RFF, Maes IH, Joore MA, et al. Specialised treatment based on cognitive behaviour therapy versus usual care for tinnitus: a randomised controlled trial. *Lancet*. 2012;379(9830):1951-1959. doi:10.1016/S0140-6736(12)60469-3

5. Moseley GL, Vlaeyen JWS. Beyond nociception: the imprecision hypothesis of chronic pain. *Pain*. 2015;156(1):35-38. doi:10.1016/j.pain.0000000000000014

6. Boehmer KR, Álvarez-Villalobos NA, Barakat S, et al. The impact of health and wellness coaching on patient-important outcomes in chronic illness care: A systematic review and meta-analysis. *Patient Educ Couns*. 2023;117:107975. doi:10.1016/j.pec.2023.107975

7. Flückiger C, Del Re AC, Wampold BE, Horvath AO. The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy (Chic)*. 2018;55(4):316-340. doi:10.1037/pst0000172

8. De Haan E, Duckworth A, Birch D, Jones C. Executive coaching outcome research: The contribution of common factors such as relationship, personality

match, and self-efficacy. *Consulting Psychology Journal: Practice and Research*. 2013;65(1):40-57. doi:10.1037/a0031635

9. Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient self-management of chronic disease in primary care. *JAMA*. 2002;288(19):2469-2475. doi:10.1001/jama.288.19.2469

10. Van den Bergh O, Witthöft M, Petersen S, Brown RJ. Symptoms and the body: Taking the inferential leap. *Neurosci Biobehav Rev*. 2017;74(Pt A):185-203. doi:10.1016/j.neubiorev.2017.01.015

11. Henningsen P, Gündel H, Kop WJ, et al. Persistent Physical Symptoms as Perceptual Dysregulation: A Neuropsychobehavioral Model and Its Clinical Implications. *Psychosom Med*. 2018;80(5):422-431. doi:10.1097/PSY.0000000000000588

12. Lorig KR, Ritter P, Stewart AL, et al. Chronic disease self-management program: 2-year health status and health care utilization outcomes. *Med Care*. 2001;39(11):1217-1223. doi:10.1097/00005650-200111000-00008

13. Hoener C, Stiles WB, Luka BJ, Gordon RA. Client experiences of agency in therapy. *Person-Centered & Experiential Psychotherapies*. 2012;11(1):64-82. doi:10.1080/14779757.2011.639460