Evidence-Based Nursing Practice: Behavioral Treatment of Persistent Auditory Hallucinations

Preconference Workshop
25th Annual APNA Conference
Anaheim, 10/19/11

Objectives

1. Explore evolution of best practice.
2. Hear overview of 10-Session Behavioral Management of Auditory Hallucinations Course including research that led to its development.
3. Experience auditory hallucinations and apply self-management strategies.
4. Leave with resources and support to teach 10-Session Course.

The Project Team

- Robin Buccheri, University of San Francisco
- Marti Buffum, VA, San Francisco
- Louise Trygstad, University of San Francisco

These speakers have no conflicts of interest or commercial support to disclose.

Review Packet of Handouts

1. Conceptual Model
2. Auditory Hallucinations Interview Guide (AHIG)
3. Unpleasant Voices Scale (0-10/UVS)
4. Safety Protocol
5. Strategies for Managing Distressing Voices
6. Interest in Teaching Behavioral Management Course form
7. Reference List

Evolution of Best Practice: Research Questions

- Can patients with PAH benefit from evidence-based behavioral strategies taught in a group setting? (pilot study VA one setting)
- In a larger sample, are benefits statistically significant and how long lasting? (9 sites VA and other outpatient)
- Can the course be taught remotely to other clinicians? (pilot study VA 6 sites)
- Can wider dissemination yield similar findings? (VA 25 sites outpatient recovery sites)
- Does expanding anxiety reduction (12 session course) enhance outcomes? (piloted in 2 sites, IRB in process for VA 25 sites)
Conceptual Model

Self-Management of Auditory Hallucinations

Beliefs Underlying our Approach

- We can all learn to be experts on managing our own symptoms.
- Managing our symptoms (asthma and migraines) has empowered us and improved our health.

Beliefs Underlying our Approach cont’d

- We would like to teach you what we have read are effective strategies and have you teach us what works for you.
- Each person is an individual—what works for one will be different from what works for another.
- We can learn from one another.

Treatment Manual

Guidelines for Teaching 10-Session Course:

Behavioral Management of Auditory Hallucinations

Behavioral Strategies Taught

1. Self-monitoring (paying attention to what makes the voices better and worse)
2. Talking with someone
3. Listening to music/radio
4. Watching TV/something else
5. Saying “stop”, ignoring the “voices”, or not doing what they tell you to do

Behavioral Strategies Taught cont’d

6. Using an earplug
7. Using relaxation exercises
8. Keeping busy
9. Taking my prescribed medications
10. Avoiding drugs and/or alcohol
Evidence: Pilot Study: (n=21)
Is course effective in a group setting?

- Pilot study with experimental & control groups and one year follow-up in VA Day Treatment Program


Pilot cont’d: AH Differences
1. Number of voices
2. Frequency of voices
3. Who the voices are
4. Location of voices

Pilot cont’d
- Participants had heard voices an average of 20+ years.
- No one had ever talked so openly about the voices or the experience of hearing voices to staff.

Pilot cont’d: AH Similarities
1. Almost all heard derogatory remarks and/or commands to do something not good for them.
2. Almost all began hearing AH during a stressful time.

Pilot cont’d: In the group voice hearers enjoyed
1. Telling their stories and describing their experience
2. Asking questions of us and each other
3. Supporting each other in group
4. Involvement in own care
5. Achieving symptom relief from self-management

Summary of Pilot
- Course was effective in a group setting.
- Managing AH is as individual as symptom itself; one strategy worked for everyone no strategy worked for everyone.
- Practicing in class and at home promoted long-term use of strategies.
- Majority of participants used strategies throughout 12 month period and had decreases in symptom severity.
Evidence: Multi-site Study
(n=62, 9 settings)
Can other clinician get same outcomes that are sustained over time?

Larger multi-site study with one-year follow-up with 50% of the participants from VA population


Multi-site study cont’d: Prevalence of Commands to Harm

Baseline
47% heard at least one kind of command to harm
44% heard commands to harm self
21% heard commands to harm others
16% heard commands to harm self and others

Multi-site study cont’d: Negative Characteristics of AH
Short term (post course):
Decreased 6 of 7 negative characteristics of auditory hallucinations:
1. Frequency (p<.001)*
2. Loudness (p<.07)
3. Self-control (p<.03)*
4. Clarity (p<.01)*
5. Negative tone (p<.03)*
6. Distractibility (p<.006)*
7. Distress (p<.02)*

(*statistically significant=p<.05)

Multi-site study cont’d: Commands to Harm Post Course, End of Course and 12 Months

<table>
<thead>
<tr>
<th>Commands to Harm</th>
<th>Baseline</th>
<th>End of Course</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>44%</td>
<td>24%</td>
<td>24%</td>
</tr>
<tr>
<td>Others</td>
<td>21%</td>
<td>16%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Multi-site study cont’d: Anxiety and Depression
Short term (post course):

Anxiety decreased (p<.02)*
Depression decreased (p<.001)*

Multi-site study cont’d:
One year follow-up
Long term (one year post course):

4 of 7 negative characteristics of AH remained improved at one year
Commands to harm self and others remained improved at year
Anxiety reduction remained improved at 3, 6, and 9 months
**Evidence: VA Dissemination Study**
Can we teach clinicians remotely?

6 VA Sites participated (inpt and outpt)

1. Hampton, Virginia  
2. Palo Alto (Menlo Park), California  
3. Sacramento, California (2 groups)  
4. Portland, Oregon  
5. North Little Rock, Arkansas  
6. San Diego, California (2 groups)  

(Buffum et al., 2009)

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**VA Dissem. cont’d:**
Staff Responses

100% reported helpful monthly conference calls

- Communication with project investigators extremely helpful
- Learning from other sites
- Opportunity to try new ideas

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**VA Dissem. cont’d:**
Patient Responses

Participants’ perceptions

98% found course helpful

- 8% minimally helpful
- 23% moderately helpful
- 42% very helpful
- 25% extremely helpful

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**VA Dissem. cont’d:**
Staff Responses

- “I learned more about the patients’ experiences.”
- “Nurses noted that the patients seemed to feel more free to talk to them about their voices.”
- “I have better criteria to use in my assessments....”

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**VA Dissem. cont’d:**
Patient Benefits

- Acceptance of self and own experience
- Learn to manage voice experience
- Identify effective strategies to use
- Build self-confidence in own ability for symptom management
**VA Dissem. con't:**

**Patient Benefits**
- Experience support from others who hear voices—not feel alone
- Increased comfort over time discussing voices with staff
- Patients compared own scores, liked having safe place to talk about voices

**Conclusions from All Evidence**
- Effective as adjunct therapy to pharmacologic treatment
- Low cost intervention, can be incorporated into many settings by existing staff
- Adaptable to individual settings
  - Inpatient, outpatient
  - Acute, chronic

**About Teaching this Course**

**Why teach this course?**
- Symptom management is empowering
- Patients interested
- Strategies helpful
- Enhanced communication
- More accurate focused assessments for harm commands

**Teaching the Course in Your Setting**
- Would the course be helpful in your setting?
- What adaptations come to mind that your facility might need or like?
- How would you implement it?
- What do you think you would need to conduct the course?

**What is it like to hear voices?**

**Experiential Exercise**

**Debriefing**

**Five Components of Implementation**

1. Increasing staff awareness through education
2. Teaching 10-session course
3. Using patient self-assessment tools
4. Facilitating communicating among staff
5. Improving discharge communication

(Buccheri, Trygstad, Buffum, Lyttle, & Dowling, 2010)
1. Increasing staff awareness

- Use simulated hearing voices exercise
- Provide reading list of articles with participant accounts of hearing voices
- Begin discussion about current assessment and treatment of auditory hallucinations in your setting

(Buccheri, et al., 2010)

2. Teaching the 10-Session Course

Behavioral Management of Persistent Auditory Hallucinations Course to help people learn to manage distressing voices.

- Highly structured and supportive
- Typically held for one hour once a week
- Each class: “Strategy of the Week”
- Individual structured interview

Teaching the 10-Session Course: Tips for Success

1. Providing an atmosphere where it is accepted to admit hearing voices.

2. Encouraging each participant to share their experiences.

3. Letting participants know that there will be variation in their responses as everyone is unique.

Teaching the 10-Session Course: Tips for Success cont’d

4. Demonstrating the strategies in the class.

5. Encouraging each participant to practice the strategies in the class.

6. Encouraging each participant to share their responses to each strategy.

Teaching the 10-Session Course: Site Adaptations

Adaptations are encouraged—e.g., teaching several times a week, 1:1

- VA San Diego’s: wallet cards, templated progress notes, scripts for participants
- VA San Francisco’s: teaching all staff, 1:1 with participants; separating initial interviews

Teaching the 10-Session Course: Class Structure

1. Collect Individual Practice Forms from previous class
2. Complete Characteristics of Auditory Hallucinations Questionnaire (CAHQ)
3. Complete the Unpleasant Voices Scale (UVS)
4. Have all participants share their scores on UVS and compare with last class
5. Teach new “strategy of the week” and why it might help
6. Practice new strategy in class
7. Distribute Individual Practice Forms practice strategy twice daily
3. Using Patient Assessment Tools

- Self-assessment tools for patients
  1) Characteristics of Auditory Hallucinations Questionnaire (CAHQ)
  2) Unpleasant Voices Scale (UVS)
- Safety protocol
- Interview guide for staff
  Auditory Hallucinations Interview Guide (AHIG)

Using Patient Assessment Tools cont’d:
Safety Protocol

It is important to assess whether participants:
1) intend to act on harm commands
2) have a past history of acting on those commands
3) have a plan
4) have the means
   (Gerlock, Buccheri, Buffum, Trygstad & Dowling, 2010)

Using Patient Assessment Tools cont’d:
Unpleasant Voices Scale (UVS/0-10)

1. Please rate your unpleasant "voices" during the last 24 hours by circling one of the following numbers: (0-10)

2. Please rate your unpleasant "voices" over the past week by circling one of the following numbers: (0-10)

Using Patient Assessment Tools cont’d:
Unpleasant Voices Scale (UVS)

3. Do you ever hear pleasant voices?
4. Are your voices commanding you to harm yourself? Intend to act on them?
5. Are your voices commanding you to harm someone else? Intend to act on them?

Robin Buccheri, Louise Trygstad & Glenna Dowling, 1997

4. Facilitating Communication among Staff

- Share results of Unpleasant Voices Scale (UVS) (e.g. handoffs)
- AHIG data and effective strategies should be in treatment plan
- Use “Charting Template”

5. Improving Discharge Communication

- For the participant:
  1) UVS assessment tool
  2) when and where to seek resources
  3) list of strategies that have worked
- For sharing information (list of effective strategies):
  1) documentation in medical records
  2) tools for case managers and care givers
  3) care plan for continuity within system
Process for Working with Us

1. Fill out Interest in Teaching Course form.
2. Will receive e-mail with information
3. Receive all materials, review materials along with training DVD
4. We will send you training DVD, treatment manual, tools, safety protocol, homework and relaxation CD.

Questions???