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.

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)

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
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: 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.
**Multi-site Study**
*(n=62, 9 settings)*

**Evidence:**
Can other clinicians 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:**
*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:**
*Anxiety and Depression*

**Short term** (post course):
- Anxiety decreased  *(p<.02)*
- Depression decreased  *(p<.001)*

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<th>Baseline</th>
<th>End of Course</th>
<th>12 Months</th>
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<td>Commands to Harm Self</td>
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<td>24%</td>
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<td>Commands to Harm Others</td>
<td>21%</td>
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**Multi-site study cont’d:**
*Prevalence of Commands to Harm* *(n=27)*

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:**
*Commands to Harm Post Course, End of Course and 12 Months*

**Baseline End of Course 12 Months**

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**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)

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

VA Dissem. cont’d:
Staff Responses

100% reported improved communication about auditory hallucinations:

1. with participants
2. with other staff (verbal report, documentation, care planning)

VA Dissem. cont’d:
Patient Responses

Participants’ perceptions
98% found course helpful

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

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 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…”
VA Dissem. cont:
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

De-Briefing

Voice Hearer:
1. How was hearing voices?
2. What was the hardest part about hearing voices for you?
3. What strategies worked for you in managing your voices?

What is it like to hear voices?

✦ Experiential Exercise
✦ Debriefing

De-Briefing

Nurse:
1. What was the hardest part about working with someone who was hearing voices?
2. What will you do differently next time you work with someone who hears voices?

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?
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).

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)

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

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???