Psychosocial Interventions for Auditory Hallucinations

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Purpose

- Provide useful information and tools that you can use to improve your patients’ voice hearing experience(s)
Definition: Hallucination

“…a false sensory perception that has the compelling sense of reality despite the absence of an external stimulus”

-APA Dictionary of Psychology
Brief History of Voice Hearing

- Socrates (4th century BC)-founder of Western philosophy and early voice hearer
- 1817-French psychiatrist Jean-Etienne Esquirol introduced concept of hallucinations into psychiatry
- 20th century—predominance of the medical over the psychological viewpoint
- 1980’s—start of the Hearing Voices Movement
Source: Harry Potter and the Chamber of Secrets (2002)
AVHs in the General Population

- 4-25% of the population report a history of AVHs (Johns, Nazroo, Bebbington, & Kiupers, 2002; Slade & Bentall, 1988; Tien, 1991)

- The majority of college students report a history of AVHs (Barrett & Etheridge, 1992; Posey & Losch, 1983)

- “Healthy voice hearers” hear more positive voices and feel more in control of their voices than psychiatric patients (Daalman et al., 2010; Honig et al., 1998)
AVHs in Psychotic Disorders
(Nayani & David, 1996)

100 psychotic patients w/ auditory hallucinations

- Average of approximately 3 voices
- Voices mostly male and middle-aged
- 61% knew the identity of one or more of their voices
- Content
  - 77% critical voices
  - 70% abusive voices
  - 66% threatening voices
  - 48% pleasant voices
- Frequency
  - 12% 1-2x/day
  - 36% several times a day
  - 37% most of the time
  - 15% all of the time
- Explanations for voices
  - 51% clash of Good and Evil
  - 16% plot (e.g. CIA)
  - 5% ghosts, spirits, or aliens
AVHs in Psychiatric Conditions
(McCarthy-Jones, 2012)

- Dissociative Identity Disorder (70-90%)
- Schizophrenia (70%)
- Posttraumatic Stress Disorder (50%)
- Borderline Personality Disorder (32%)
- Bipolar Disorder (7%)
The Role of Trauma

- 70% of voice hearers from the general population reported that their voices began after a traumatic event (Romme & Escher, 1989)

- 13-30% of bereaved people heard the voice of their deceased spouse (Grimby, 1993; Rees, 1971)

- Dose-response relationship between childhood abuse and “pathology level” psychosis (Janssen et al., 2004)
  - Mild abuse (2x)
  - Moderate abuse (11x)
  - Severe abuse (48x)
AVHs: A Simplified Model

Source: http://pelajaribiologi.blogspot.com/2012/05/area-broca.html
Voices Over Time

- Mitchell and Vierkant (1989) compared hallucinations in patients admitted to an East Texas hospital in the 1930s and 1980s

- 1930s-hallucinations reflected desire for material goods; made benign commands (e.g. “be a better person”)

- 1980s-technological concerns w/ negative and destructive commands (e.g. kill oneself or others)
Voice-Hearing in Three Different Countries
(Luhrmann, Padmavati, Tharoor & Osei, 2015)

- Structured interview-based comparison of hearing voices in the USA, Ghana, and India (n=60)

- In USA
  - Identified as symptoms of a brain disease
  - Few described personal relationships with their voices

- In Ghana and India
  - More positive voice-hearing experience
  - Experienced their voices as people—had human relationships with their voices
Assessment
Cognitive Assessment of Voices: Interview Schedule
(Chadwick & Birchwood, 1994)

- Characteristics of voices
- Content
- Antecedents
- Affect
- Behavior
- Identity
- Meaning
- Power
- Compliance
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Disagree</th>
<th>Unsure</th>
<th>Slightly Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>1. My voice is punishing me for something I have done</td>
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<td>2. My voice wants to help me</td>
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<td>3. My voice is very powerful</td>
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<td>4. My voice is persecuting me for no good reason</td>
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<td>5. My voice wants to protect me</td>
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<td>6. My voice seems to know everything about me</td>
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<td>7. My voice is evil</td>
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Reaction to Hypothetical Contradiction (RTHC)

- Person is asked how, if at all, a specific hypothetical and contradictory occurrence would affect his/her belief
  - “What if on this date… the world did not end like the voices predict?”
  - “What if a priest told you that God would not want you to kill yourself?”
Interventions for Hallucinations

Source: http://psychcentral.com/lib/schizophrenia-basics-delusions-hallucinations-onset/
Common coping strategies

- Fight (e.g. yell at voices, attack perceived source)
- Flight (e.g. sleep, drink alcohol)
- Freeze (e.g. isolate self, stay in bed)
- Submit (e.g. comply w/ voice commands)
Cognitive Behavioral Therapy for Psychosis (CBTp)

- **Meta-analysis** (Wykes, Steel, Everett, & Tarrier, 2008)
  - 33 randomized clinical trials (N=1964)
  - Patients were on antipsychotics but continued to endorse symptoms of schizophrenia
  - Reduction in positive symptoms, negative symptoms, depressive symptoms, and social anxiety
  - Improvement in functioning
  - Small to medium effect size

- **Group CBT for voices**
  - Reductions in convictions in beliefs about omnipotence and control of voices (Chadwick, Sambrooke, Rasch, & Davies, 2000)
  - Improvement in social functioning 6 months post-therapy compared to TAU (Wykes et al., 2005)
The Cognitive Model

“It’s not one’s life situations that cause distress but rather one’s interpretations or appraisals of them.”

-Aaron T. Beck, MD
CBT TRIANGLE

**Situation**
Hears voice say, “You’re the queen.”

**Automatic Thoughts**
“It’s happening. I will rule soon.”

**Behavior**
Smile benevolently to others, speak in a condescending manner

**Emotions**
elated, excited, powerful
Cognitive Model of Hallucinations

**STIMULUS**
Hears voice say, “Don’t eat.”

**BELIEFS**
Voices are powerful, credible, external, benevolent

**INTERPRETATION**
“It’s God. He’s trying to save me.”
“They’re trying to poison me.”

**SUSTAINED FOCUS**
Unstructured time alone; hungry; voices increase

**EMOTIONS**
Fear, Anger

**BEHAVIOR**
Don’t eat, yell at staff members
Interactions between beliefs

(Hayward, Strauss, & Kingdon, 2012)

Voices are powerful

Voices intend harm

I am powerless

Associated with the most distress
Targets of Treatment

- Beliefs about voices
- Beliefs about the self
- Safety behaviors
- Relationship with voices & others
- Depression & anxiety
- Illness beliefs
Normalization

- Psychoeducation (e.g. rates in the general population, throughout history, etc.)
- Famous people who hear/heard voices
- Self-disclosure
- Our shared potential for voice hearing
Famous People Who Have Heard Voices

Source: http://hearingvoicescymru.org/positive-voices/famous-voice-hearers
Guided Discovery

I CANNOT TEACH ANYBODY ANYTHING. I CAN ONLY MAKE THEM THINK.
- Socrates

Painting by Jacques-Louis David (1787)
<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Situation (Where were you? Who were you with?)</th>
<th>Content of voices (What did the voices say?)</th>
<th>Feelings (How did you feel in response to the voices?)</th>
<th>Actions (What did you do? How did you cope?)</th>
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<tbody>
<tr>
<td>12/1/15</td>
<td>Eating dinner w/ parents, mom tried to talk to me</td>
<td>“You’re a loser.”</td>
<td>sad (85%), lonely (60%)</td>
<td>didn’t really answer mom’s questions, went to room</td>
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<td>12/2/15</td>
<td>Watching TV in room alone</td>
<td>“Pathetic. You’re pathetic.”</td>
<td>angry (40%)</td>
<td>blasted music (mom knocked on my door and I ignored her)</td>
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<tr>
<td>What is the thought?</td>
<td>• Is it <strong>totally true</strong>? (Evidence for/against? Any <em>other/better</em> explanations?)</td>
<td>If not, correct the thought so that it’s totally true &amp; helpful.</td>
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</table>
| God wants me to be with him. He wants me to kill myself. | • Not totally true; God wouldn’t want me to hurt myself or cause pain to my family.  
• Not helpful; It just makes me want to kill myself. | God wants me to be safe. He wants me to be there for my family. |
Behavioral Experiments

With your patient

Identify the problematic belief

Collaboratively design a specific and reasonable experiment to test it out

Carry out the experiment

Reflect and draw conclusions
LOOK, POINT, NAME
Coping Strategies
(Kingdon & Turkington, 2005)

- **Behavioral control** (e.g. taking a warm bath)
- **Socialization** (e.g. talking to a friend)
- **Mental healthcare** (e.g. taking meds)
- **Symptomatic behavior** (e.g. shouting at voices)
- **Cognitive control**
  - Distraction (e.g. listening to music)
  - Focusing (e.g. letting the voice be)
  - Rational responding (e.g. making an appt. to listen to voices, normalizing explanations, being assertive)
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The Use of Acceptance and Commitment Therapy to Prevent the Rehospitalization of Psychotic Patients: A Randomized Controlled Trial

Patricia Bach and Steven C. Hayes
University of Nevada, Reno

The present study examined the impact of a brief version of an acceptance-based treatment (acceptance and commitment therapy; ACT) that teaches patients to accept unavoidable private events; to identify and focus on actions directed toward valued goals; and to defuse from odd cognition, just noticing thoughts rather than treating them as either true or false. Eighty inpatient participants with positive psychotic symptoms were randomly assigned to treatment as usual (TAU) or to 4 sessions of ACT plus TAU. ACT participants showed significantly higher symptom reporting and lower symptom believability and a rate of rehospitalization half that of TAU participants over a 4-month follow-up period. The same basic pattern of results was seen with all participant subgroups except delusional participants who denied symptoms.

Nearly 4% of all schizophrenics who initially are medication responsive and continue to be medication compliant are rehospitalized each month, at a cost to society approaching one billion dollars a year (Weiden & Olsson, 1995). There are many reasons for rehospitalization (Doering et al., 1998), but part of this problem may be traced to the persistence of auditory hallucinations and delusions in the seriously mentally ill (SMI). Even with medication, these positive symptoms persist at least at low levels for many SMI patients (Breier, Schreiber, Dyer, & Pickar, 1991), and such symptoms are among the predictors of rehospitalization in this population (e.g., Sota, 2000). Thus, the SMI patients may require psychosocial interventions to help them cope with those symptoms that medication does not eliminate.

Psychosocial programs focused on hallucinations and delusions have generally emphasized methods designed to reduce the frequency, intensity, or believability of these symptoms. Treatment methods include verbal challenges to belief, planned reality testing, and distraction activities. However, these methods, while highly effective, are not without limitations. The ability of patients to believe that their thoughts are not true or to engage in reality testing activities is limited by the belief that these thoughts are literally true. Thus, patients may continue to experience the symptoms and thus reduce the behavior that leads to poor functioning and rehospitalization.

It is possible, however, that these positive outcomes might be undermined if patients use suppression and avoidance as a method of regulating experiential content. Thought suppression is a coping strategy that tends to be applied to private experiences with high social disapproval or to those with content related to harming one’s self or another (Freeston & Ladouceur, 1993; Purdon & Clark, 1994), and thus, psychotic symptoms are a natural target for this strategy. Unfortunately, thought suppression can actually increase the frequency of unwanted thoughts (Salkovskis & Campbell, 1994; Wegner, Schneider, Carter, & White, 1987) and reduce conscious control over simultaneously occurring overt behaviors (Bargh & Chartrand, 1999). This risk is not merely academic, as psychotic patients report using deliberate ignoring and distraction as methods of suppressing psychotic symptoms (Shergill, Murray, & McGuire, 1998).
Compassion Focused Therapy

Developed by Prof. Paul Gilbert for individuals who experience high shame and self-criticism.

Roots in Evolutionary, Social, Developmental, and Buddhist Psychology.

Braehler, et al. (2013)

RCT comparing group CFT (16 sessions) to TAU.

CFT associated with greater clinical improvement and increased compassion, reductions in depression and perceived social marginalization.
Dr. Eleanor Longden (TED Talk)
Hearing Voices Groups

- Group principles
  - Hearing voices is a natural and meaningful part of the human experience
  - Diverse explanations for voices are both accepted and valued
  - Voice-hearers are encouraged to take ownership of their experiences and define it for themselves
  - Voices can be interpreted in the context of life events and interpersonal narratives
  - Importance of peer support
Voice Dialogue Method

- Developed by Drs. Hal and Sidra Stone in 1993
- Based on the assumption that we all have various sub-personalities that make up ourselves
- Voices are asked questions about their characteristics and their role(s)
- Can lead to re-framing of voices
Summary

- How we conceptualize voices has an impact on the voice hearing experience
- Psychosocial interventions can ameliorate the distress associated with hearing voices
- Voices can be viewed as symptoms to eliminate, symptoms to cope with, or experiences to better understand—which view is likely to cause/ameliorate the most distress?
Further resources
On-line resources

- http://www.hearing-voices.org/
- http://www.intervoiceonline.org/tag/hearing-voices-groups
- https://copingtutor.com/
- http://recoveryfromschizophrenia.org/cbt-for-psychosis-trauma-psychosis-handouts/
References


