



Auditory Hallucinatory Beliefs in Patients With Schizophrenia: Association of Auditory Hallucinations With Social Interactions, Characteristics and Emotional Behaviors Over 3 Months



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ABSTRACT

The aims of this study were to explore social interactions, characteristics, and emotional behaviors to detect changes in auditory hallucinatory beliefs in patients with schizophrenia over a 3-month period. Participants ($n = 189$) were evaluated using the Auditory Hallucinations Assessment Scale (AHAS) and the Assessment of Communication and Interaction Skills (ACIS). The characteristics and emotional behaviors measured by the AHAS showed improvements, while auditory hallucinatory beliefs became less influential. Social interaction scores increased regardless of changes in auditory hallucinatory beliefs. Psychiatric professionals need to train those who hear voices to react to them with indifference.

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Positive and negative symptoms, cognitive symptoms, mood symptoms, and certain social and occupational dysfunctions are core symptom clusters in schizophrenia. These core symptoms impact interpersonal relationships. Effective interpersonal communication and high-quality interpersonal interactions are key elements of the recovery process for patients with schizophrenia (Chien & Chan, 2013); unfortunately, patients lack the ability to socialize, and their symptoms impact their social interaction abilities during the rehabilitation process (Grant & Beck, 2010). People with schizophrenia feel lonely even when there are other people around, and thus have difficulty interacting with others (Erdner, Nyström, Severinsson, & Lützén, 2002). A study exploring the relationship between social skills and symptom severity in a community of 72 patients with chronic schizophrenia found that patients with poor social skills displayed serious symptoms (Pinkham, Penn, Perkins, Graham, & Siegel, 2007). Furthermore, patients with schizophrenia lack the motivation to socialize (Kring & Elis, 2013), which limits their opportunities to put their social skills into practice. Psychotic symptoms also prevent patients from engaging in social activities (Brown, Tas, Can, Esen-Danaci, & Brüne, 2014). In an observational study of patients with schizophrenia, Yilmaz, Josephsson, Danermark, and Ivarsson (2008) reported that participants had difficulties expressing their desires and initiating interactions with others. Evidence has shown that insufficient or impaired social interactions are associated with psychotic symptoms and a lack of motivation or social skills.

ASSOCIATION OF AUDITORY HALLUCINATORY CONTENTS AND BELIEFS WITH AH CHARACTERISTICS AND PATIENTS' EMOTIONAL RESPONSES/BEHAVIORS

Auditory hallucinations (AHs) are a core psychotic symptom, and they influence patients' mood. Recent studies have shown that AHs are associated with depression and suicidal ideation in individuals who hear voices, i.e., voice hearers (Chiang, Chen, & Yang, 2013; Connor & Birchwood, 2013). The content of AHs is associated with the voice hearer's attitude toward and belief in his or her AHs. Previous studies have shown that AHs with negative content may lead to emotional distress. Johns et al. (2014) pooled data from several non-clinical cases of AHs that led to emotional disturbances and suggested that these patients need clinical help; however, voice hearers who believe that their AHs are beneficial often do not seek professional assistance. Chiang et al. (2013) found that voice hearers who heard soothing and protective voices had stronger tendencies toward suicidal ideation, indicating that the belief that AHs are beneficial has an adverse impact on patients. The above-mentioned studies indicate that AHs with beneficial content have inconsistent effects on voice hearers. Psychiatric nurses should make an effort to minimize the impact of AH on patients instead of labeling their content as positive and beneficial or negative and detrimental; moreover, the same voice hearer may hear both positive and negative content. The impacts of AHs on patients vary with their content. Therefore, in addition to focusing on the content of AHs, more emphasis should be placed on patients' attitudes toward or beliefs in their AHs, whether these beliefs change over time, and the effects that changes in beliefs have on these patients.

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Association of AH Contents and Patients' AH Beliefs With Social Interactions

Patients' social interactions are influenced by AHs. Some voice hearers regard their AHs as supportive and comfortable; they tend to accept their AHs, and their hallucinations help them feel relaxed when they experience difficulties in real-life social activities (Sanjuan, Gonzalez, Aguilar, Leal, & van Os, 2004). Jones (2010) observed that the relationships between voice hearers and AHs undergo a dynamic developmental process that is similar to the development of real interpersonal interactions. Therefore, voice hearers might retreat into the world of AHs when they encounter frustrating interpersonal interactions. Paulik (2012) indicated that the occurrence of AHs might be influenced by interpersonal interactions. The AHs might also be triggered by problems that arise in interpersonal relationships (Sorrell, Hayward, & Meddings, 2010). These studies imply that AHs and social interactions mutually influence each other.

Social interactions are an important factor in the recovery continuum of schizophrenia patients (Yanos, Roe, & Lysaker, 2010). To date, research addressing this topic has been confined to cross-sectional studies that focus on the relationships between social interactions and positive symptoms. Few studies have examined the prospective relationships between AHs and social interactions. This study aimed to examine the prospective relationships by addressing the following research question: What is the impact of changing auditory hallucinatory belief statuses on AH characteristics and the emotional behaviors and social interactions of schizophrenia patients over a 3-month period? It is worth exploring the effects of patients' changing beliefs about their AHs, such as whether such changes may lead to the amelioration of depressive symptoms.

This study had two primary aims. The first aim was to examine the association of AH characteristics and AH-related beliefs and emotional behaviors with concurrent and prospective social interactions in patients with schizophrenia over a 3-month period. The second aim was to explore changes in auditory hallucinatory beliefs and their relationships with AH-related characteristics and emotional behaviors and social interactions in patients with schizophrenia over a 3-month period.

METHODS

Design

This study was a 3-month prospective follow-up study involving repeated AHAS and ACIS measurements in patients with schizophrenia during the rehabilitation process.

Study Procedure

From August 2012 through May 2013, we collected data from 10 inpatient rehabilitation units in a psychiatric hospital. The psychiatric inpatient rehabilitation units provided the following patient services: (1) regular medication; (2) psychosocial interventions; (3) guidance on health-promoting lifestyles (e.g., diet, exercise, physical activity and smoking cessation); (4) assistance with managing everyday activities, such as personal hygiene, laundry, and shopping; and (5) vocational therapy and training.

We recruited people between the ages of 20 and 65 years who were hospitalized in rehabilitation units and who were stable at the time of data collection. The participants were diagnosed with schizophrenia according to the criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. We excluded patients who had intellectual disturbances or substance abuse issues through a chart review. A sample of 189 participants was recruited using convenience sampling. The participants were asked to provide demographic data and to complete the short form of the Auditory Hallucination Assessment Scale (AHAS) at baseline and 3 months later. Each questionnaire

took approximately 10 minutes to complete. This study was approved by the Human Subjects Research Committee (No 11-S-011).

Study Variables and Measurement

The original *Auditory Hallucinations Assessment Scale (AHAS)* consists of 32 items with three subscales, each of which assesses one construct. The AHAS was developed by Frederick (2000) by integrating existing global schizophrenia symptom scales and 7 rating scales specifically for hallucination assessments. The AHAS focuses on the holistic assessment of AHs, including various characteristics of AHs (such as clarity, loudness and reality) and voice hearers' positive or negative attitudes toward the AHs. Apart from the voice hearers' personal beliefs and attitudes toward AHs, the development of the AHAS was guided by the principles of rational emotive behavior therapy, which divides the AH behavior process into three constructs: activating events (A), beliefs (B), and the consequences of hearing voices (C). Construct C encompasses the emotional and/or behavioral consequence that follows from the belief. The AHAS, which was translated into Chinese and back-translated into English, was used to measure the auditory hallucinatory symptoms of 183 schizophrenia patients in Taiwan (Chiang & Yang, 2011). Recently, the AHAS was reduced to a 22-item short version that was validated in 171 patients with schizophrenia (Chiang et al., 2013). The 22-item version was selected for this study. An exploratory factor analysis yielded meritorious Kaiser–Meyer–Olkin (KMO) values (.89) and significant Bartlett's tests of sphericity, indicating that the AHAS has good construct validity. The internal consistency ranged from .805 to .903 for the subscales and .914 for the total score (Chiang et al., 2013). The Cronbach's α values for the 22-item AHAS were .931 at baseline and .950 at the 3-month follow-up in this study. The three dimensions of the AHAS short form are (1) characteristics (6 items; for example, 'I hear voices when I am by myself'); (2) beliefs (3 items; for example, 'My hallucinations are soothing and comforting', 'The voices I hear are helping or protecting me', 'The voices I hear help me to do some things better'); and (3) emotional behaviors (13 items; for example, 'Hearing voices makes me feel depressed').

The beliefs subscale of the AHAS includes 3 items, with scores ranging from 3 to 12. A higher score on the belief subscale indicates that the AH content has a greater influence on the participant. A lower score on the belief subscale indicates that the participant is indifferent to the AHs. The changes in the AH beliefs scores from baseline to the 3-month follow-up (3 months minus baseline) were computed. The change scores for AH beliefs were grouped as (1) less influential change (change score < 0): the content became less influential to the individual, (2) no change (change score = 0) or (3) more influential change (change score > 0): the content became more influential to the individual.

The *Assessment of Communication and Interaction Skills (ACIS)* was developed by Forsyth, Lai, and Kielhofner (1999). Hsu, Pan, and Chen (2008) translated and validated the Chinese version of the ACIS. The ACIS is an observer rating scale that includes 20 communication and interaction skills as observed from participants' interactions with others in a particular context. There are three subscales: physicality, information exchange and relations. The ACIS, which includes 20 items, was assessed using standardized observations from the professional staff. We observed and assessed the interpersonal interaction performance of the patients while receiving group therapy. Both Forsyth et al. (1999) and Hsu et al. (2008) examined its validity and reliability. Two studies demonstrated that the instrument worked well to capture communication and interaction skills and was discriminable and reliable among clients. The Observation and Evaluation Handbook developed by Hsu et al. (2008) was used to train the observers before the assessments were performed. After the training, the inter-rater reliability was evaluated and the resulting intra-class correlation coefficient (ICC) was 0.81. Trained observers rated performances on a scale of 1 to 4, in line with the ACIS assessment guide. A rating of 4 indicates a socially competent performance. A rating of 3 is given if the participant's

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