Auditory Hallucinations Interview Guide
Promoting Recovery with an Interactive Assessment Tool

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ABSTRACT
The Auditory Hallucinations Interview Guide (AHIG) is a 32-item tool that helps psychiatric-mental health (PMH) nurses assess past and current experiences of voice hearers so they can provide more individualized care. The AHIG was developed as a research tool but has also been found to be clinically useful in both inpatient and outpatient settings to help voice hearers and nurses develop a shared terminology of auditory hallucinations (AH). Using the AHIG, voice hearers are able to tell their stories in a structured and safe environment, thus encouraging recovery. Through respect and active listening, PMH nurses can communicate unconditional acceptance, caring, and hope for recovery, which helps develop rapport and promote trust in the nurse–patient relationship. Once trust is developed, voice hearers and PMH nurses can work together to find effective strategies for managing AH, including commands to harm self and others. [Journal of Psychosocial Nursing and Mental Health Services, 53(1), 20-28.]
Assessing patients who experience auditory hallucinations (AH) can be challenging. Psychiatric-mental health (PMH) nurses typically ask patients with known or suspected AH the following two questions: (a) “Do you hear voices?” and (b) “Are your voices commanding you to harm yourself or anyone else?” Although asking these questions is critically important to maintaining the safety of these patients and others, additional questions exist that should also be asked to obtain a comprehensive assessment of voice hearers’ experiences. Such a thorough assessment of AH can help PMH nurses begin to understand what hearing voices is like for each patient, what strategies are effective for managing AH, and what help patients may need from staff.

To date, no published interview guide exists with the following two-fold purpose: (a) to help PMH professionals assess and plan care for each individual’s voice hearing experience, and (b) to help patients tell their unique stories of hearing voices. The current article describes the development and use of the Auditory Hallucinations Interview Guide (AHIG), a clinically useful assessment tool that PMH nurses can use to collect assessment data necessary for developing individualized care plans for voice hearers, including plans to ensure the safety of all. The AHIG helps voice hearers describe their experiences of hearing voices from initial onset to current experiences, including what makes their voices better and worse. The AHIG also teaches voice hearers and PMH nurses a shared language, which increases their comfort level and facilitates effective communication when talking to each other about AH.

**BACKGROUND**

**Review of Existing Instruments to Assess Auditory Hallucinations**

Past methods to gain an understanding of AH have included interactive and semistructured interviews, global measures of schizophrenia with subscales for AH, dimensions and characteristics of AH, and self-report measures. These methods are presented in two reviews of AH assessment tools (Frederick & Killeen, 1998; Ratcliff, Farhall, & Shawyer, 2011).

The review by Frederick and Killeen (1998) explored 10 instruments developed between 1973 and 1995 to assess AH. Seven were clinician-rated, and three involved self-report; in addition, nine were quantitatively measured, whereas one was composed of open-ended questions about characteristics of AH. What emerged from this review was the recognition of patients’ capability to think about and discuss their symptoms and begin to understand the dimensions of AH. From the reviewers’ perspective, two weaknesses existed, including small study samples and the fact that the only studies on the tools were written by the tools’ authors. The reviewers reported that future research should include larger samples for improved psychometric testing, inclusion of patient beliefs and attitudes, and inclusion of physiologic imaging studies and genetic dimensions.

The Ratcliff et al. (2011) review explored 10 instruments developed to assess AH between 1998 and 2009. Two were structured interviews, and eight were self-report. The two interviews overlapped somewhat in quantitative measurement of AH characteristics. Differences involved measures of impact on self-esteem, compliance with commanding voices (without measuring presence of commanding voices), attention to voice content, and perception of reality of voices. The authors concluded that most tools need refinement and more reliability and validity testing; more focus is also needed on dimensions of clinical and theoretical concern, including the impact of the voices on distress, behavioral influence, and life disruption. Furthermore, valuable information must be obtained from the voice hearers themselves.

In both sets of reviews, the subjective experience of voice hearing is absent. Neither review discusses the interactive experience with any tool. While obtaining data for assessment, an actual interview as a clinical tool for establishing a therapeutic relationship was not elucidated in the literature.

**Development of the Auditory Hallucinations Interview Guide**

In 1991, the second author (R.K.B.) spent 1 year as a visiting faculty member with the Symptom Management Faculty Group at the University of California, San Francisco. In 1992, the first two authors (L.N.T., R.K.B.) decided to focus their research using symptom management to help individuals with schizophrenia who have persistent AH learn how to manage their symptoms. Few descriptions of the experience of AH existed in the literature, and most standardized psychiatric interviews asked few questions about AH.
The first part of the nursing process is assessment, and no evidence-based guidelines existed for nursing assessment of the experience of AH. Without evidence-based guidelines, a qualitative exploration is needed to determine variable of interest. Using all the descriptions of AH found in the literature, the dimensions of the experience (i.e., inside the head or outside the head; louder than my voice or quieter than my voice) were assembled to create an interview schedule to guide a qualitative study of the experience of AH. This interview guide was used to answer the following research question: What is the experience of having persistent AH for individuals with schizophrenia? The creation of this interview guide was part of a larger pilot study that tested the 10-Session Behavior Management of Auditory Hallucinations Course (Buccheri, Trygstad, Kanas, Waldron, & Dowling, 1996).

**Theoretical Underpinnings of the Auditory Hallucinations Interview Guide**

Peplau’s Theory of Interpersonal Relations. Comprehending the voice-hearing experience requires genuine desire and interactive skill to learn the voice hearer’s story. The interview method for understanding the AH experience is grounded in Peplau’s (1989, 1991) interpersonal theory, which supports the use of communication skills that foster the therapeutic relationship between nurse and patient and specific roles of the nurse to create trust and foster growth. By using skills such as empathy, listening, and attentive and focused interest in a safe and comfortable environment, the nurse can conduct a comprehensive assessment with an individual who experiences AH. Using the AHIG, the individual’s story can be elicited and includes the following: (a) the name he or she gives what he or she hears (e.g., voices, sounds, music); (b) circumstances about when the voice(s) began; (c) whether voices have continued and when; (d) how many he or she hears; (e) what makes them better or worse; (f) whether the voice(s) are familiar; (g) characteristics of the voices; (h) amount of distress or pleasure; and (i) whether voices command him or her to harm him/herself or others. Whether conducted all at one time or over multiple sessions, the assessment includes the identification of the individual’s needs relating to current symptoms (e.g., relief from distress) and begins a collaborative plan of care.

Some researchers purport that a voice hearer’s understanding and meaning about his or her own voices are key to recovery (Place, Foxcroft, & Shaw, 2011; Romme & Escher, 2000). Describing experiences with voices to a caring clinician promotes comfort in feeling heard and a beginning understanding of oneself; these elements are critical for a therapeutic relationship (Peplau, 1991). The nurse helps clarify content to enable the patient to understand and interpret his or her own experience (Peplau, 1991). Nurses use these multiple interpersonal skills to help patients attain their most optimal level of wellness.

**Symptom Management Theory.** The theory of symptom management was developed by the Symptom Management Faculty Group at the University of California, San Francisco (Humphreys et al., 2008). The purpose of the theory is to provide a framework for researchers and clinicians to collaborate in improving symptom assessment, symptom treatment, and the outcome of treatment. The main concepts of symptom management theory are the symptom experience, symptom management strategies, and symptom status outcomes. The theory describes the interaction of these three concepts and stresses the importance of examining these concepts within the context of the individual (i.e., demographic, psychological, sociological, physiological, and developmental), his or her environment (i.e., physical, social, and cultural), and his or her health and illness (i.e., risk factors, health status, disease, and injury).

These two theories provided a framework that guided the development of the AHIG.Peplau’s theory of interpersonal relationships provided guidance for establishing the relationship through which the AHIG should be administered—specifically, with respect for the individual and his or her AH experience and using nonjudgmental active listening to develop rapport and trust with the voice hearer. Administering a tool to assess AH in this manner helps develop the nurse-patient relationship so that the nurse and patient can then work together to assess the patient’s experience of AH and find effective strategies to manage AH.

Symptom management theory provided a comprehensive framework for the content of the AHIG. This theory guided the development of questions about the symptom experience, symptom management strategies, and symptom status outcomes of using those strategies. The dimensions of the AH experience found in the literature, together with these two theories, were used to develop the AHIG.

**DESCRIPTION OF THE AUDITORY HALLUCINATIONS INTERVIEW GUIDE**

The AHIG comprises 31 open-ended questions and one question with multiple yes/no responses about the experience of hearing voices; it was developed by the authors of the current article (L.N.T., R.K.B.) and reflects both the literature and the authors’ clinical experiences (Table). The AHIG is an assessment tool that can be used to create individualized interventions. It takes approximately 30 to 45 minutes to complete. It is not a diagnostic tool, and it does not result in a score. The AHIG can be used to complement other tools; it could be administered first to help develop rapport and trust, and then other assessment tools could be administered as needed.

The AHIG has been recently described in an article titled Self-Management of Unpleasant Voices: A Tested Practice Model (Buccheri et al., 2013). The AHIG is one of three assessment tools used in this practice model to assess the experience of AH.
Content of the Auditory Hallucinations Interview Guide

The experience of hearing voices is an internal and highly personal experience that is unique to each individual. The content of the AHIG provides important information about the dimensions of the experience for each individual. It establishes the presence of sounds (i.e., voices, music, and/or other), whether it is believed others can hear these, and whether the experience is distressing, positive, pleasurable, or all of these. What each voice hearer has learned to do to cope and make himself or herself more comfortable is explored. It covers (a) the age of onset of hearing voices; (b) what was happening in the individual’s life when the voices began; (c) the individual’s current experience, including the identity or anonymity of the voices; (d) what the voices say; (e) whether they are hostile, friendly, or both; and (f) commands from the voices, including commands to harm self and/or others. Other questions asked about the voices include (a) how long they talk; (b) whether they talk to the hearer or about the hearer; (c) what the location of the voices is; (d) what is their loudness, frequency, and clarity; (e) what time of day are they heard; (f) in what places and situations are the voices usually better and worse; and (g) what the effects of medications, alcohol, and drugs are on the voices. History includes whether the voices have ever gotten much better or much worse, and if so, what was the situation (or difference) at that time.

Process of the Auditory Hallucinations Interview Guide

Building trust encourages voice hearers to feel safe, which is a primary goal of the interview. At the beginning of the interview, the AHIG script provides directions to promote trust and feelings of safety (Table).

FINDINGS
Findings From Two Decades: Reports and Observations From Using the Auditory Hallucinations Interview Guide

The AHIG has been used for more than 20 years in studies that evaluated outcomes of the 10-Session Behavioral
Management of Persistent Auditory Hallucinations Course. This 10-session course teaches voice hearers strategies to manage their AH (Buccheri et al., 1996; Buccheri, Trygstad, & Dowling, 2007; Trygstad et al., 2002). The evidence-based course has been widely disseminated in many countries (Buccheri & Trygstad, 2012), across the United States, and at multiple times in Veterans Affairs facilities (Buffum et al., 2009; Buffum, Buccheri, Trygstad, & Dowling, 2014).

The clinicians who have participated in research evaluating this 10-session course used the AHIG and reported the voice hearer as more comfortable joining the course when the AHIG had been conducted as an introductory interview. Furthermore, clinicians reported evidence of a bond between the interviewer and the voice hearer, thereby facilitating comfort during the course.

One of the earliest observations in using the AHIG was the connection (i.e., rapport) established between the interviewer and patient. This rapport still exists for the current authors with patients who were interviewed in 1994 and 1995, as well as with those interviewed since then. Because of the knowledge the interviewer has of the patient from conducting the AHIG, as well as from the shared experience in the 10-session course, it is easy for the PMH nurse to inquire about the well-being of the AH hearer and provide support and suggestions based on knowing specific information about the hearer.

In early interviews, patients repeatedly said they had never talked about their voices with anyone, and many did not know that others heard voices as well. The individual interviews were

<table>
<thead>
<tr>
<th>TABLE (CONTINUED)</th>
<th>AUDITORY HALLUCINATIONS INTERVIEW GUIDE (AHIG)</th>
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<tbody>
<tr>
<td>18. Do your voices command or suggest:</td>
<td></td>
</tr>
<tr>
<td>that you harm/hurt yourself? Yes No</td>
<td></td>
</tr>
<tr>
<td>that you harm someone else? Yes No</td>
<td></td>
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<tr>
<td>that you do something? What? Yes No</td>
<td></td>
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<tr>
<td>comment on what you are doing? Yes No</td>
<td></td>
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<tr>
<td>make critical comments about you? Yes No</td>
<td></td>
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<tr>
<td>laugh at you? Yes No</td>
<td></td>
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<tr>
<td>talk about religion or God? Yes No</td>
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<tr>
<td>talk about sex? Yes No</td>
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<tr>
<td>19. What helps you in each of these situations listed in the previous item if you do not want to hear the voices? (Review list for experiences in item #18 that the individual responded yes to.)</td>
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<tr>
<td>20. When in the day are the voices worst?</td>
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<td>21. Is there a time of day when you do not hear voices?</td>
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<tr>
<td>22. Do your voices awaken you in the morning or during the night?</td>
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<tr>
<td>23. Sometimes where people are and what they are doing is associated with more or fewer voices—Is that true for you?</td>
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<tr>
<td>24. What influence does medication have on the voices?</td>
<td></td>
</tr>
<tr>
<td>25. Does an extra dose (PRN) of medication help? Which medication?</td>
<td></td>
</tr>
<tr>
<td>26. What effect does alcohol have on the voices?</td>
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<tr>
<td>27. What effect do drugs have on the voices? Identify different effects of different drugs.</td>
<td></td>
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<tr>
<td>28. How old were you when you first started hearing voices?</td>
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<tr>
<td>29. What was happening in your life when you first heard voices? Tell me about the experience.</td>
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<tr>
<td>30. Have the voices ever gone away or gotten significantly better? If so, what do you think caused the improvement?</td>
<td></td>
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<tr>
<td>31. Have your voices ever gotten worse? If so, what do you think caused your voices to get worse?</td>
<td></td>
</tr>
<tr>
<td>32. What else can you tell me about your experience with voices that I have not asked?</td>
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</table>

Note. PRN = as needed. 
Findings from Using the Auditory Hallucinations Interview Guide: Demographics, Commonalities, and Variations in Voice Hearing Experience

The following is a summary of specific findings from a study that used the AHIG as a data collection tool with 62 participants (Trygstad et al., 2002).

Demographics. The mean age of participants in the 10-session course was 44.1 (range = 23 to 72 years). The majority of participants were male (72.6%, n = 45), and 27.4% (n = 17) were female. Participants were multiethnic: 71% (n = 44) were White; 14.5% (n = 9) were Black or African American; 4.8% (n = 3) were Hispanic or Latino; 6.5% (n = 4) were Chinese; and 2.8% (n = 2) classified themselves as Other. The majority (62.9%, n = 39) of participants were single; 17.7% (n = 11) were married; and 19.4% (n = 12) were widowed or divorced. None were employed full time, but approximately one third (32.2%, n = 20) did some paid or volunteer work.

The age when AH first began for participants ranged from 1 to 47 years (mean = 24.8 years). Some voice hearers could not remember a time when they did not hear voices. They reported that they have heard voices for as long as they could remember. Others (38%, n = 8) did not hear voices until they were at least 30 years old.

Commonalities. Commonalities existed among voice hearers; specifically, the majority of voice hearers reported that AH were distressing to them. These unpleasant voices were usually derogatory and often suggested performing harm to themselves or others. Another commonality was the stressfulness of the onset and a need to keep their voice hearing a secret. Many patients talked about the stigma and isolation they experienced when their friends and family found out they heard voices. According to authors’ and clinicians’ anecdotes, voice hearers often report that they think they are the only ones who hear voices.

Many participants reported enjoying some of the voices (e.g., “They keep me company”; “They laugh at my jokes”; “They remind me to take a shower”). In teaching strategies to manage distressing voices, it has always been emphasized that voice hearers are welcome to keep any pleasant voices they want to keep; the purpose of teaching them behavioral strategies was the management of unpleasant or distressing voices.

Many participants reported that being in a structured situation, such as the 10-session course, was helpful. For those who had had some of their AH disappear, the consistent description was of gradual fading rather than abrupt cessation.

Variations. The number of voices heard ranged from one to hundreds, and frequency varied from “occasionally” to “24 hours a day, 7 days a week.” These descriptions remain accurate in the authors’ current work with individuals who hear AH. Variations in the AH experience also included the location of the voices, what was heard, the frequency of the voices, the identity of the voices, the gender of the voices, whether they personally knew the voices, and whether voices were attributed to individuals who were dead or alive. Some voice hearers thought that the voices were coming from where they lived only to learn that after moving, their voices moved with them.

Differences were also noted in the time of day when voices were worst (e.g., on awakening, afternoon, evening and night), and whether voices awakened participants from sleep. Effects of situations of low structure and low stimulation (e.g., being home alone) and high stimulation (e.g., crowded bus or grocery store) were also reported differently; however, all of these situations usually made voices worse.

What Clinicians Have Learned From Using the Auditory Hallucinations Interview Guide

Beneficial as an assessment tool, the AHIG can be used to guide interventions. When clinicians gather information from voice hearers, questions may trigger insight about their experiences that may not be readily apparent. For example, one AHIG question pertains to a time when voices stopped.
KEYPOINTS


1. The Auditory Hallucinations Interview Guide (AHIG) allows voice hearers to share their auditory hallucination (AH) experiences in a structured and safe manner.

2. The benefits of using the AHIG are that the patient and psychiatric-mental health nurse establish rapport and develop trust while learning a shared terminology and way of communicating about AH.

3. The AHIG can add important individualized information to a patient’s care plan (e.g., specific AH triggers and effective strategies that help manage his or her AH).

Do you agree with this article? Disagree? Have a comment or questions? Send an e-mail to the Journal at jpn@healio.com.

Some voice hearers who were United States military Veterans shared that their voices discontinued during basic training and restarted afterward. This change was attributed to intensive physical and mental engagement, as well as highly structured schedules. A number of similar questions in the AHIG explore the change and characteristics of AH throughout the day and across the lifespan. These questions demonstrate that AH symptoms are not categorically static as voice hearers often report. The intensity, loudness, frequency, or tone of voices, for example, can fluctuate depending on the time of day, level of life engagement, presence of triggers, and general level of stress.

Voice hearers are often surprised by the AHIG interviews. They commonly report that they rarely had clinicians who explored their AH symptoms in such detail in the past. Some voice hearers paused and contemplated during the interview as if they never thought of their voices in such a manner. Instead of responding to voices reactively and automatically as they often do, voice hearers begin a process of discovery about what the voices are like and how they experience such voices. The self-awareness and insight they achieved during the AHIG interview paved the way for future intervention. For example, if an engaged life (i.e., basic training in the military) stopped the voices, what can a voice hearer do to increase life engagement that could potentially help modulate his or her symptoms? If voices mimic the words a voice hearer’s abusive father said to him or her, what choices would he or she have in response to the voices? Because of its role in self-discovery, the AHIG can be most beneficial if it is used at the early phase of a clinical relationship. It allows voice hearers to be experts and be engaged in a process of guided discovery with their clinicians.

The AHIG offers the opportunity for clinicians to listen, not make assumptions. The following interview summary demonstrates how a clinician can use the AHIG to create a climate of trust by asking his or her client about his voices and listening to him tell his story while helping him understand the meaning of his experience.

Clinician: Do you remember our first visit? What do you remember about it?

Voice hearer: You are the first person I told about my voices. Up until then, I only spoke briefly about them. I told you the bad time I had in a great deal of detail.

Clinician: What made you decide to share your experiences with me?

Voice hearer: You made me very comfortable about talking with you. I thought I killed and raped my family when I first started having symptoms. When you have something for 6, 7 years, the relief you had about speaking with someone....

It was a realistic fear. Every night you went to bed, you feared that you would wake up in hell. When I spoke with others, they looked at my alcohol history and thought my voices had to do with my drinking. I was already sober for a year! It was not because of my drinking. Some thought I had multiple personalities. They did not listen.

Clinician: Were there questions you remember the most about that visit?

Voice hearer: Spirituality. It was never brought up before. For me, my struggle was about heaven and hell, about morality. Like the Babylonian King [Nebuchadnezzar] who became insane and saved by God, mine is a spirituality journey.

IMPLICATIONS FOR NURSING PRACTICE AND RESEARCH

Using the AHIG yields many benefits, including allowing voice hearers to share their experiences of AH in a safe, structured manner. The AHIG provides structure for PMH nurses to invite patients to answer detailed questions during an individual interview about the onset of their voices and the voice hearing experience. These questions include asking about AH triggers and strategies patients use to help manage their AH, including commands to harm self and others.

Using the AHIG provides PMH nurses with the opportunity to convey empathy and practice good listening skills, which help build trust between voice hearers and mental health professionals. The AHIG provides shared terminology for experiences that may have been difficult for the voice hearer to describe to others. This terminology can then be shared with other mental health professionals working with the voice hearer toward recovery. For example, information collected with the AHIG can be used to develop an individualized care plan for the voice hearer. This care plan could include that the voice hearer prefers to have his voices called “thoughts” or that he hears commands to harm self but has never acted on them.
Students in psychiatric nursing often have a difficult time trying to talk to individuals with schizophrenia. The structure of the AHIG allows students and patients to feel more comfortable talking to one another. Students are often fascinated with what they learn during the interview and are pleased to be able to connect with patients; in addition, patients feel heard, and soon, the interaction progresses easily within the structure.

All tools require ongoing evaluation. The authors continuously seek feedback from clinicians who have incorporated the AHIG into their work with voice hearers in inpatient and outpatient settings. Any changes for brevity, flow, and content can then be re-evaluated. Clinicians often make alterations that better fit their situations. Therefore, the authors welcome others to use the AHIG and to submit feedback by completing the Feedback Form (Appendix) and sending it to Dr. Robin K. Buccheri at buccheri@usfca.edu.

Future research is needed for establishing the usefulness of the AHIG for mental health clinicians from all disciplines in inpatient and community care settings, as well as for informal caregivers (e.g., support groups) and family members. In addition, a continuity of care evaluation is needed for the utility of the individualized care plan developed from the AHIG information.

CONCLUSION

PMH nurses must learn more about each voice hearer’s past and current experiences so they can provide individualized nursing care. The AHIG provides a structured 30- to 45-minute interview that can be used to assess voice hearers’ past and current symptoms and develop a therapeutic relationship. The AHIG contributes a theory-based, clinically tested, structured interview guide to the PMH nurse’s repertoire of assessment and communication tools. The tool has benefits for staff, nursing students, and voice hearers. By using the valuable communication skills of listening and conveying empathy, PMH nurses can establish a trusting and comfortable relationship that enables patients to be open and honest about hearing voices.

REFERENCES


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The authors have disclosed no potential conflicts of interest, financial or otherwise. This project was funded by a grant from the University of San Francisco Faculty Development Funds. This material is the result of work supported with resources and the use of facilities at the San Francisco Veterans Affairs Medical Center, San Francisco, California, and Iowa City Veterans Affairs Health Care System, Iowa City, Iowa. This article is dedicated to all of the psychiatric mental health nurses and other mental health clinicians who work diligently to help their patients learn how to manage their auditory hallucinations and stay safe.

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Received: July 21, 2014
Accepted: November 14, 2014
Posted: December 10, 2014
doi:10.3928/02793695-20141203-01
Feedback Form

We invite you to use the Auditory Hallucinations Interview Guide (AHIG) in your practice and hope you will send us feedback about your experience using this interview guide. We value your feedback, look forward to receiving it, and will use your feedback to continue to improve the interview guide. Please send it by e-mail to Dr. Robin K. Buccheri at bucherir@usfca.edu. You may e-mail the same address to ask about teaching the 10-session course or joining our research team to teach the revised 12-session course that is part of a research study.

Feedback requested after using the AHIG

1) Who administered the AHIG (please select all that apply)?
   a) _____psychiatric-mental health nurses
   b) _____psychologists
   c) _____psychiatric social workers
   d) _____psychiatrists
   e) _____students_________________ (insert discipline)
   f) _____other____________________ (insert discipline)

2) Was the AHIG useful to you in working with patients who hear voices?
   a) _____yes
   b) _____no

3) If yes, how was the AHIG useful to you in working with patients who hear voices?

4) Did you use information you gained from the AHIG to develop an individualized care plan for your patient(s)?
   a) _____yes
   b) _____no

5) Did you share information you learned from the AHIG with (please select all that apply)?
   a) _____members of the treatment team
   b) _____community caregivers
   c) _____family or friends of the voice hearers

6) Any other feedback you would like to provide?