Responding to Command Hallucinations to Harm

The Unpleasant Voices Scale and Harm Command Safety Protocol

ABSTRACT
Command hallucinations are relatively common in voice hearers and are taken seriously because of the potential threat to self and others. Many variables mediate the relationship between hearing commands and acting on them. This article describes the implementation of the Harm Command Safety Protocol and the Unpleasant Voices Scale to respond to command hallucinations to harm in the context of the dissemination of a multisite, evidence-based behavioral management course for patients with auditory hallucinations.
Scale (UVS) to monitor harm command hallucinations and the implementation of the Harm Command Safety Protocol to respond to harm command hallucinations within the context of a course for the management of auditory hallucinations (Buffum et al., 2009).

**BACKGROUND**

**Harm to Self**

According to the first report of data from the National Violent Death Reporting System (NVDRS), 56% of all violent deaths in the 16 states participating in NVDRS in 2005 were suicides (Karch, Lubell, Friday, Patel, & Williams, 2008). The report also noted that suicides by former and current military personnel comprised 20% of all reported suicides.

Comparing data for 2001-2005 from the National Death Index to the NVDRS data, James B. Peake, MD, the Secretary of Veterans Affairs, testified before Congress that suicide rates for both male and female veterans surpassed the suicide rates of their male and female nonveteran counterparts in the general population (“Issues Related to Collecting Suicide Data,” 2008). Ongoing analysis of research from the Serious Mental Health Treatment, Research, and Evaluation Center (SMITREC) indicates diagnoses of major depressive disorder, schizophrenia, bipolar disorder, substance use disorder, and anxiety disorders are consistently linked to an increased risk for suicide in all VHA patients (internal VHA memorandum, September 1, 2009).

Seventy percent to 95% of suicides are committed by individuals with a diagnosable mental illness. Of the factors that place individuals at increased suicide risk, schizophrenia is one of the most frequent mental health disorders associated with suicide, second only to depression (Montross, Zisook, & Kasckow, 2005).

When conducting a suicide assessment, practitioners assess specific modifiable and nonmodifiable risk factors, and signs and symptoms that may place individuals at increased suicide risk. Modifiable risk factors include, but are not limited to, severity of illness, comorbid substance use, and the presence of firearms. Nonmodifiable risk factors might include age, gender, and ethnicity.

In addition, practitioners determine patients’ immediate safety concerns and the most appropriate intervention and setting for treatment (American Psychiatric Association [APA], 2003). An initial step is for practitioners to ask patients directly whether they have had thoughts about taking their life, whether they have a plan to do so, and whether they have ever tried doing so (APA, 2003; Shea, 2002). An answer of yes to the first two questions identifies individuals as being at immediate risk that requires further inquiry and intervention.

**Harm to Others**

Certain characteristics may increase the risk of harming others. Swanson, Borum, Swartz, and Monahan (1996) studied the association between psychotic symptoms
and violent behavior. They hypothesized certain psychotic symptoms that involved a perceived threat and internal control-override (TCO) would be associated with increased violence. The authors explained TCO as “rationality-within-irrationality” (Swanson et al., 1996, p. 311). For instance, when individuals with a psychosis feel threatened (e.g., feeling threatened secondary to hallucinations and delusions) and when their internal controls are compromised (e.g., defense or retaliation against another when they believe the harmful action is directed against them), then their violence toward another makes sense in the context of their internal world.

Swanson et al. (1996) found individuals with schizophrenia who had delusions and hallucinations (specific to the TCO symptoms) had increased odds of violence in the community in the preceding year. Those individuals with one or more of the TCO symptoms were more than twice as likely as individuals with other psychotic symptoms to engage in violence in 1 year. The researchers suggested a risk assessment of individuals with mental illness should include an inquiry into feelings of being threatened by others and being in control of one’s thought processes.

In an epidemiological study, TCO symptoms again were found to be strongly related to violent behaviors and explained a substantial part of the association between violence and psychiatric diagnosis (Link, Monahan, Stueve, & Cullen, 1999). When TCO symptoms were controlled for, other severe psychotic symptoms were not related to the indicators of violence.

**DANGEROUSNESS OF COMMAND HALLUCINATIONS TO HARM**

Command hallucinations are relatively common in voice hearers, with between 33% and 74% of voice hearers reporting command hallucinations (Birchwood & Chadwick, 1997). Although the estimated range of voice hearers is variable, there is also evidence that command hallucinations are underreported (Braham, Trower, & Birchwood, 2004).

Studies of command hallucinations often are limited by small samples and a retrospective methodology, relying on interviews with voice hearers. In a review of the literature from 1990 to 2000, Braham et al. (2004) found that in all studies, command hallucinations had some impact on the behavior of the individuals who experienced them. However, many variables mediate the complex relationship between hearing commands and acting on them.

Evidence of compliance with command hallucinations is also variable, ranging from 15% to 88.5% (Shawyer, Mackinnon, Farhall, Trauer, & Copolov, 2003). In three of the studies examined, the rates of compliance were 80% or higher (Braham et al., 2004). Some of the commands are benign (e.g., brush your teeth), but others can be violent and dangerous (e.g., stab your mother). Kasper, Rogers, and Adams (1996) found that 92% of individuals reported compliance with command hallucinations ordering violence to self and 67% complied with orders of violence toward others.

Command hallucinations can be distressing, with the distress linked to the uncontrollability of the experience (Close & Garety, 1998). Risk of acting on the command hallucinations is mediated by beliefs about the voice, content of the instruction (the severity), presence of congruent delusions, and the intensity of the emotional response (Braham et al., 2004).

**Command Hallucinations to Harm Self**

According to Harkavy-Friedman et al. (2003), patients who have made a previous suicide attempt and are currently hearing command hallucinations to harm themselves may be at increased suicide risk. In addition, knowing the identity of the speaker, accepting the voices as “real,” and having an emotional response (e.g., fear, despair, anger) places patients at significantly greater risk of acting on the command (Erkwoh, Willmes, Eming-Erdmann, & Kunert, 2002).

**Command Hallucinations to Harm Others**

Command hallucinations to harm others place both patients and others at risk. As with command hallucinations to harm self, characteristics of the hallucination impact the likelihood of patients responding to the command. For example, the likelihood of responding to a command is increased when patients indicate the following:

- They are distressed.
- Their delusions fit with their command hallucinations to harm others (Junginger, 1990, 1995; Swanson et al., 1996).
- They feel they have little control over the voices (Beck-Sander, Birchwood, & Chadwick, 1997).
- They have few coping strategies (Mackinnon, Copolov, & Trauer, 2004).
- They know the speaker (Junginger, 1995), accept the speaker as real, have an emotional response (e.g., fear, despair, anger) (Erkwoh et al., 2002), or consider the speaker as an authority figure or as benevolent and omnipotent (Beck-Sander et al., 1997).
In 2005, a project to disseminate an evidence-based, group-format, 10-session course for the management of auditory hallucinations commenced by recruiting sites from VHA medical centers across the nation. The dissemination project leaders for the management of auditory hallucinations course included two of the authors of the original research (R.B. and L.T.) and two psychiatric advanced practice nurses (APNs) working in mental health settings at different VHA medical centers (M.D.B. and A.A.G.). Sites were recruited by presenting the project to APNs on an established monthly conference call via the national VHA APN network. To disseminate the evidence-based intervention, the project leaders arranged monthly conference calls and ongoing monitoring and mentoring of the APN course leaders at the six participating sites.

All sites were provided with the treatment manual, training DVD, instruments, and homework; sites also participated in one or two training sessions. Monthly follow-up telephone conferences were scheduled to allow APN course leaders at the participating sites to problem solve, ask questions, and exchange supportive strategies about various aspects of implementing the course.

The original research has demonstrated positive outcomes in reducing negative characteristics of auditory hallucinations, and levels of anxiety and depression (Buccheri et al., 2004; Buccheri, Trygstad, Kanas, & Dowling, 1997; Buccheri, Trygstad, Kanas, Waldron, & Dowling, 1996; Trygstad et al., 2002), as well as commands to harm (Buccheri, Trygstad, & Dowling, 2007). To systematically monitor the process of disseminating an evidence-based intervention, all participating sites first obtained appropriate institutional review board and VHA research and development approvals.

Six VHA sites, including both inpatient and outpatient settings, participated. The 10-session course was conducted by APN course leaders who asked patients to complete instruments that allowed auditory hallucinations monitoring. For example, patients completed an instrument to assess their harm command hallucinations at each group session. To respond to harm command hallucinations revealed in the UVS, a safety protocol was developed for rapid risk assessment. Each site completed a course evaluation and provided feedback about all elements of the dissemination project. Details of how this dissemination project was implemented and results of the project have been reported previously (Buffum et al., 2009).

**Instruments**

The UVS was first developed in 1997 and has been refined over time. It has been used nationally

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**Table 1. The Unpleasant Voices Scale.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>1. Please rate your unpleasant “voices” during the past 24 hours by circling one of the following numbers:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Please rate your unpleasant “voices” over the past week by circling one of the following numbers:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you ever hear pleasant voices? Please circle one</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Are your voices commanding you to harm yourself?</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>5. Do you intend to harm yourself?</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>6. Are your voices commanding you to harm someone else?</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>7. Do you intend to harm someone else?</td>
<td>Yes*</td>
<td>No</td>
</tr>
</tbody>
</table>

* If you answered “yes”, please stay after and speak to one of the group leaders. Thank you.
and internationally with hundreds of patients. The UVS informs the dangerousness of command hallucinations, suggests the likelihood of patients acting responsively, and provides additional information about safety concerns when used concomitantly with the Harm Command Safety Protocol.

**Unpleasant Voices Scale.** The UVS was designed to help assess the intensity of patients’ hallucinations by having them rate the unpleasantness of their voices (Figure 1). The first two questions on the UVS ask patients to rate the intensity of their unpleasant voices on a scale of 0 (no voices heard) to 10 (the most unpleasant your voices could be) during the past 24 hours and past week. The third question asks whether patients heard pleasant voices. For this dissemination project, questions four through seven were added to the UVS to determine whether patients heard command hallucinations to harm self or others and whether they intended to act on those commands.

The UVS was completed by patients during each of the 10 course sessions. The Harm Command Safety Protocol was enacted if patients responded yes to hearing voices commanding them to harm self or others and yes to intending to act on those voices.

**Harm Command Safety Protocol.** The Harm Command Safety Protocol was developed as a rapid assessment tool to an expressed intent to harm self or others that could be used to quickly determine the need for immediate intervention.

### Intent to Harm Self:

When a patient responds yes to question 5 on the Unpleasant Voices Scale (“...intent to harm self”), determine whether there is a need for the patient to be assessed for hospitalization. This will be especially important if the patient also indicates the voices are loud and distressing, and the patient does not feel that he or she has much control over the voices (questions on the Characteristics of Auditory Hallucinations Questionnaire—CAHQ; Buccheri et al., 2004).

After class or group, talk privately with the patient and use this script to determine the need for further assessment:

- “You marked here that the voices are commanding you to harm yourself. It can be very scary to hear voices telling you to harm yourself.”
- “What is (are) the voice(s) commanding you to do to yourself?”
- “Do you plan to carry this out?”
- “Do you have the means to carry this out?” (Credible?)
- “Has (have) the voice(s) ever commanded you to do this before?”
- “Have you ever harmed yourself as the voice(s) said to do?”
- “How long ago?”

If the patient indicates that he or she has attempted suicide before (because of the voices), has the means and intent, is distressed, and does not feel much control over the voices, then refer the patient for an evaluation for hospitalization.

- “We (I) would like to get some extra help with this today, and would like you to wait with us (me) until the psychiatrist/crisis team (insert whatever is appropriate for your setting) is able to see you?”

### Risk Assessment Checklist*

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the means to kill/harm self (credible threat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tried to kill/harm self previously</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome today (who notified):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* If yes to intent to harm self

**Continue to monitor for change under these conditions:** patient has chronic suicidal command hallucinations, has never acted on them, does not have the means, has no intent, is not distressed, and feels in control.

Figure 2. Harm Command Safety Protocol, Intent to Harm Self.
**Intent to Harm Others:**

When a patient responds yes to question 7 on the Unpleasant Voices Scale (“…intent to harm someone else”), determine whether there is a need for the patient to be evaluated for hospitalization. This will be especially important if the patient also indicates the voices are loud and distressing, and the patient does not feel he or she has much control over the voices (questions on the Characteristics of Auditory Hallucinations Questionnaire—CAHQ; Buccheri et al., 2004).

After class/group, talk privately with the patient and use this script to determine the need for further assessment:

- “You marked here that the voice(s) is (are) commanding you to harm someone else. It can be very scary to hear voices telling you to harm someone else.”
- “What is (are) the voice(s) commanding you to do?”
- “Is there someone specific the voice(s) is (are) commanding you to hurt?”
- “Do you plan to carry this out?”
- “Do you have the means to carry this out?” (Credible?)
- “Has (have) the voice(s) ever commanded you to do this before?”
- “Have you ever harmed others as the voice(s) said to do?”
- “How long ago?”

If the patient indicates past history of harm or killing others before (because of the voices), has the means and intent, is distressed, and does not feel much control over the voices, then refer the patient for an evaluation for hospitalization.

- “We (I) would like to get some extra help with this today, and would like you to wait with us (me) until our psychiatrist/crisis team (insert whatever is appropriate for your setting) is able to see you?”

**Be aware that intent to harm someone (or intent to harm “others in general”) triggers a duty to warn and protect the individual(s) identified. It may mean having a staff member stay with the patient until an evaluation can be done.**

**Risk Assessment Checklist**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the means to harm others (credible threat)</td>
<td></td>
</tr>
<tr>
<td>Previously tried to or has harmed others.</td>
<td></td>
</tr>
<tr>
<td>Outcome today (who notified):</td>
<td></td>
</tr>
</tbody>
</table>

*If yes to intent to harm others

**Continue to monitor for change with the following conditions:** patient has chronic homicidal command hallucinations, has never acted on them, does not have a target in mind (person or event), does not have the means, has no intent, is not distressed, and feels in control.

The Harm Command Safety Protocol is a scripted response to guide the group leader in assessing the need for immediate intervention when patients have responded yes to hearing voices commanding them to harm self or others and yes to intending to act on those voices on the UVS. Some harm auditory hallucinations are chronic and change little over time. The Harm Command Safety Protocol enables the group leader to monitor these hallucinations for change, increased potential danger, and urgency for intervention.

The Harm Command Safety Protocol assesses three major risk components to command hallucinations to harm self or others:

- Patient has expressed intent to hurt self or others.
- Patient has the means and the plan to do so (i.e., the threat is credible).
- Patient has a prior history of hurting self or others.
The Harm Command Safety Protocol is not intended to replace a full suicide and homicide risk assessment. Rather, it is a tool for rapid assessment that can be quickly conducted after a group session to determine whether further intervention is needed (Figures 2 and 3).

A summary sheet for UVS and harm command hallucinations tracking is completed for each patient at the end of each class. The summary sheet includes data from the UVS and indicates whether the Safety Protocol was initiated.

Figure 4 shows a completed summary sheet. The summary sheet makes it easier to monitor a patient's weekly responses during the 10-week course. The group leader can quickly review the summary sheet to assess changes in the intensity of the unpleasant voices and intent to harm self or others as well as determine whether the Safety Protocol was initiated.

**OUTCOME AND CONCLUSION**

The Safety Protocol was triggered only once at one site during the project. While participating in the course, an inpatient reported command hallucinations to kill herself. When the APN course leader implemented the Safety Protocol, the patient’s suicide plan was revealed. Prioritizing further intervention, the patient’s length of stay was prolonged by 1 day, and appropriate measures were taken to ensure her safety during and after the hospitalization.

The UVS allows patients an opportunity to reveal whether they are hearing command hallucinations and whether they intend to act on them. The Harm Command Safety Protocol provides direction to course leaders if patients indicate intent to respond to their command hallucinations. Both the UVS and the Harm Command Safety Protocol provide additional critical information about command hallucinations to harm self and others, which is often overlooked when auditory hallucinations are assessed. In addition, both provide an opportunity for patients to talk to course leaders about their command hallucinations, thus lessening their alienation and estrangement from others.

The Harm Command Safety Protocol is a practical, easily implemented, low-risk clinical assessment tool that has demonstrated improved safety in actual practice with patients with schizophrenia. Although future research should address its validity and reliability, its valuable safety features have demonstrated clinical utility. Hence, the Harm Command Safety Protocol should be used in conjunction with the UVS in all settings in which nurses care for patients with schizophrenia who hear command hallucinations.

**REFERENCES**


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**KEY POINTS**

1. Unpleasant voices and commands to harm can be assessed with the Unpleasant Voices Scale to monitor change over time.

2. Commands to harm can be assessed for likelihood of actual harm with a safety protocol.

3. The Harm Command Safety Protocol is an easily implemented assessment tool that has demonstrated improved safety in patients with schizophrenia.

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Do you agree with this article? Disagree? Have a comment or questions? Send an e-mail to the Journal, at jpn@slackinc.com. We’re waiting to hear from you!

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This article is dedicated to the nurses who work to decrease the suffering of their patients with auditory hallucinations.

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