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Person-based cognitive therapy groups for distressing voices: A thematic analysis of participant experiences of the therapy

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ABSTRACT

Objectives: This study set out to develop an understanding of participants' experiences of person-based cognitive therapy groups for distressing voices.

Design: Qualitative data was gathered during 10 interviews with participants of PBCT groups for people distressed by hearing voices.

Methods: A semi-structured interview was used to guide the interviews and data were analysed using thematic analysis (Braun & Clarke, 2006).

Results: Three themes unique to PBCT emerged: relating to voices, relating to self and relating to others. The value of a mindfulness approach and the importance of changed beliefs about voice strength and power emerged as sub-themes in the 'relating to voices' theme. A sense of self separate to voices and a developing positive view of self emerged as sub-themes in the 'relating to self' theme. The 'relating to others' theme referred to changed social relationships during and following the group.

Conclusions: The study provided support for the value of PBCT groups for distressing voices. Findings from the study supported the mechanisms of change suggested by the therapy model, namely, that benefit is gained through re-evaluating beliefs about voices, strengthening positive self-schema, mindfulness practice and principles and through moving towards a symbolic sense of self.

INTRODUCTION

Developments in cognitive behavioural therapy (CBT) have been at the forefront of a shift towards reducing distress associated with voice hearing. In its original form, CBT for psychosis (CBTp) focuses on identifying and evaluating beliefs about voices (Chadwick et al, 1996). A recent meta-analysis of 34 randomised trials of CBTp found modestly beneficial effects, but only a small effect size for the most robustly conducted studies (Wykes et al, 2008). This suggests that modifications to CBTp may be warranted.

There has been recent interest in drawing on mindfulness based approaches for psychosis. Using mindfulness meditation practice people are encouraged to notice unpleasant experiences such as self-critical thoughts or voices without either suppressing these experiences or ruminating on them, as both thought-suppression and rumination have been shown to be counterproductive and to increase distress (Nolen-Hoeksema, 2000). Emerging evidence supports the benefits of mindfulness practice for psychosis in terms of improved psychological health (Chadwick et al, 2005; Chadwick et al, 2009).

Person-based cognitive therapy (PBCT; Chadwick, 2006) is an approach which integrates CBTp with a mindfulness-based approach. PBCT aims to reduce distress through working within four domains. Two domains draw on CBTp approaches by supporting people to: (1) identify and evaluate unhelpful beliefs about voices ('symptomatic meaning'); and (2) identify and evaluate positive and negative beliefs about self and others ('schema'). The two other domains draw on mindfulness based approaches by encouraging people to: (3) develop a different relationship with voices through mindfulness practice ('relationship to internal experience'); and (4) develop a more fluid, complex and changing sense of self ('symbolic self'). A recent evaluation of nine PBCT groups for voices demonstrated significant improvements in psychological health and reductions in distress (Dannahy et al, 2011).

Although Dannahy et al (2011) found significant improvements following PBCT groups, their study was not able to assess which, if any, of the four domains of PBCT contributed to improvement. Indeed, it is possible that improvements could be attributable to non-specific group therapy factors rather than to any one of the four theorised domains. Goodliffe et al (2010) used a grounded theory approach to analyse the experiences of participants within the initial six (of nine) PBCT groups conducted by Dannahy and colleagues. These initial groups were conducted over 8 weeks and participant accounts provided support for the first two domains (changes to beliefs about voices and beliefs about schema), though participants spoke less of mindfulness practice or a different conceptualisation of sense of self. In response to these findings, the final three PBCT groups ran for 12 weeks, and included more mindfulness practice (including home practice) and more time for guided discovery following practice. .

The current study evaluates participants' experiences of this revised 12 week version of PBCT groups for distressing voices using a Thematic Analysis approach. Thematic Analysis (Braun & Clarke, 2006) allows a realist epistemological position to be taken and an inductive approach to the analysis (rather than theoretical) will allow themes to be derived from the interview data, limiting imposition the PBCT model. In order to further ensure an inductive approach to the analysis the primary researcher was not a part of the PBCT research team and was unfamiliar with the PBCT approach during the data collection and analysis period. The research question was 'how do participants experience group PBCT for distressing voices?'

METHOD

Participants

Ten people (five women) participated in one of three PBCT groups. Eight had an ICD-10 diagnosis of schizophrenia or of a non-specified psychosis, one had an ICD-10 diagnosis of PTSD and one was diagnosed with a non-specified personality disorder. Participants were aged between 36 and 55 years ($M=47.2$ years) and all described themselves as White British. Eight participants were

currently unemployed and two had further or higher education qualifications. All participants were receiving NHS secondary mental health care.

Therapy groups lasted for 12 weeks and were facilitated by two Clinical Psychologists experienced in CBTp. Following completion of the therapy groups, 'completers' (participants who attended six or more sessions – 23/26 participants) were invited to meet to discuss their experience of therapy. Ten people chose to take part (43% of completers).

Semi-structured Interview

A semi-structured interview schedule was developed to guide the interviews, based on the guidelines of Smith (1995). A process of intentional iteration took place, whereby the interview schedule had been adapted from a previous schedule used by Goodliffe et al (2010). The interview schedule (available from corresponding author) utilized a number of neutral open-ended questions (with suggested prompts), which were designed to explore participant's experiences in six broad areas: 1) reasons for attending the group, 2) expectations of therapy groups 3) experience and understanding of the therapeutic processes, 4) understanding of their voices, 5) perceptions of sense-of-self, 6) wellbeing following the group and their general feelings about the benefits of therapy. Interviews were conducted within two months of the completion of therapy by the first author. She remained curious and flexible in an attempt to allow participants to fully explore their experience without feeling constrained by the structure of the schedule. Interviews ranged between 35-60 minutes (mean = 46 minutes) in duration, were digitally recorded and transcribed verbatim.

Analysis

The research team consisted of clinical psychologists with experience of working with people with distressing psychosis. Interviews, transcription, coding and identification of candidate themes was conducted independently by the first author (a trainee clinical psychologist), who was not involved

in the therapy groups and did not attend research team meetings in order to limit expectations from overly influencing these stage of the analysis.

Coding of the data followed the phases of analysis described by Braun and Clarke (2006). From the initial patterns preliminary codes were generated and then collated into candidate themes. Candidate themes were reviewed, refined and checked for internal homogeneity and external heterogeneity to ensure that they produced a coherent and meaningful analysis. This process involved two levels of reviewing and refinement. Initially candidate themes were reviewed at the level of coded data extracts, whereby all transcript extracts for each theme were read to ensure that they formed a coherent pattern. If any data extracts were seen to not 'fit' with candidate themes, new themes were developed or reworked to accommodate extracts. For extracts that did not work within pre-existing or newly created themes, these extracts were discarded form analysis. Once all themes had been reviewed, a 'thematic map' of candidate themes was produced and applied to the second level of thematic refinement in which candidate themes were considered in relation to the entire data set to see if they 'accurately' reflected the data set as a whole. That is, comments from one participant could not result in a theme. Throughout the analysis process, therefore, the researcher often moved back and forth between the coded data, the entire data set, and the themes identified, coding any additional data that may have been overlooked in earlier coding. Once candidate themes had been refined, a description of the 'essence' of the themes was used to define each theme and sub-theme (Braun & Clarke, 2006). This final stage was in collaboration with the research supervisors and the implications of this are considered later.

RESULTS

Qualitative analysis of the interview data generated three themes relevant to the research question. The themes all refer to changed relationships – with voices, the self, and other people.. Please note that real names have not been used.

Relating to voices

Developing Mindfulness Skills

Many group members highlighted mindfulness practice as being useful. For most, mindfulness was a new technique they learnt within the group. Group members described two broad benefits from mindfulness: acquiring a different attitude to voices and noticing changes in voice characteristics.

Richard described acquiring a different attitude to voices:

... we learnt to, um, not put our voices out of our head, but work with them rather than try and get rid of them ... cos I had always been taught to try and get rid of them, but they-they said "don't try and get rid of them, work with them" ... [that was] unusual to start with, very unusual. But it does work.

Another participant, Anna reflected on this changed attitude to voices, despite the voices still being present:

Um, the voices are still quite bad now, so, but I have ways of dealing with them now, which I didn't have before like, like the mindfulness practice, so if things get too much, which they often do, then I'll do a mindfulness and sort of like give myself a break for, for 15 minutes. [...] Which doesn't sound a lot, but it's sort of like, when you're used to you know listening to them all the time [...] 15 minutes is like a lifetime.

This different attitude reflected some acceptance of voice hearing experiences, and similar attitudes were reported by other participants despite the continued presence of voices.

Whilst some participants described little change in voice characteristics other participants spoke of changes to voices through mindfulness practice such as voices becoming quieter and more distant. Adam described how voice hearing experiences changed during mindfulness practice:

mindfulness – that for me was a, was a main event, and, if you do mindfulness then ... if you can reach a mindful state – if you know what that is – then everything slowly begins to relax and ... and when your voice talks to you, I find that, um, I'm able to absorb it rather than, rather than have it hit me.

Some participants described difficulties in using mindfulness, particularly at first. For example Susan said that after the first group “mindfulness ... made me feel very upset” but that week by week mindfulness got “better and better”. With practice most participants described becoming accustomed to the technique and finding it easier to engage in. Many participants talked about continued use of mindfulness between sessions and after the group had ended.

Only one participant, Phil, talked about not finding mindfulness helpful, preferring instead to use distraction techniques to cope with his voices:

it didn't suit me, you know what I mean, um... I suppose it could have helped other people but it just didn't, didn't help me

He did not describe finding mindfulness increasing distress but rather that mindfulness was not “my cup of tea”.

Strength and power over voices

Prior to the group members often viewed themselves as powerless in relation to their voices – adjusting their behaviour in accordance with their voices instructions. During therapy, participants

felt better able to stand up to their voices and therefore felt less controlled by them. Jason provided an example of this:

One thing I learnt was [...] that I could take a stand against [the voices]. ... Not necessarily allow them to overtake me – to control me.

This was significant, as following voice instructions had led some participants to carry out harmful or dangerous behaviours. The process by which perceptions of power changed appeared to be related to beliefs about the power of voices and their ability to harm, with many participants feeling less likely to believe threats given by their voices. Rachael described this change:

It's made me stronger, in the fact that, um, if I do get the voices again badly not to listen to them, and not to – not to believe everything they say. So that's one positive aspect of it. Because before I just used to believe everything they'd say and then follow their instructions and it used to get me into trouble, you know. I used to do things out of character and disappear and, you know, so, you know, if I was to get the voices again badly I'd know not to listen to them and not to take notice of them as much.

The experience of talking to other group members appears to have facilitated this process. By talking about their experiences and receiving feedback from other group members, participants felt better able to challenge beliefs about their voices' control and believability and as such re-evaluate themselves in relation to their voices, recognising they had more power and control than they had previously realised.

Adam: Cos people were picking up on other people's ideas and experiences and just giving it a try for themselves and finding out that they, they could do things that they never thought they could do before ...

Whilst group members described increased confidence and power, they also acknowledged that this change was not complete as some participants described their voices becoming louder and more critical following group sessions. Therefore the change in strength and power over voices was sometimes in the context of increased voice activity.

Relating to self

Identity beyond voices

Prior to the group several participants described a sense of lost identity through the experience of hearing voices, often feeling defined by their diagnosis or the content of their voices. The process of being in the group and having their experiences normalized helped group members to develop a new understanding of themselves as a person, rather than being defined by their voices. Rachael described the change in how she thought about herself:

I feel that, that, you know, that I am a person at the end of it, even despite these voices, I'm still, you know, Rachael and I'm still a person, still have my own, my identity. But, um, I was beginning to lose that a bit, you know before I did the group. You know, I was beginning to lose my identity just seeing myself as a, constantly as an ill person – mentally ill person and I was becoming very depressed by that.

Participation in therapy groups also allowed some group members to re-evaluate beliefs about hearing voices and the concept of 'madness'. Through repositioning their experiences outside of an illness more, participants started to feel less stigmatized and began to view themselves as 'normal' and less defined by their voice hearing experiences:

Tom: I'm normal and stable now.

Interviewer: You're normal and stable?

Tom: Um hmm.

Interviewer: That's how you, how you think of yourself now?

Tom: Uh huh.

Interviewer: And what makes you normal and stable?

Tom: Um, knowing who I am basically.

Establishment of positive self

The process of being involved in the group and hearing feedback from other group members aided a different or more positive sense of self as it allowed participants to re-evaluate views of themselves as 'bad', or as being in some way to blame for their voices. Through having negative beliefs about themselves challenged and having their feelings validated by other participants, group members were provided with an alternative perspective to the views they had developed through being isolated in their experiences. This was particularly important for group members who experienced their voices telling them to harm themselves or others. Anna described the impact that receiving feedback from other group members had on her beliefs about herself:

I think it did affect the way I was feeling about myself because um, mainly because of the group sort of like feeling the same as I did, cos one thing is if you hear voices that tell you to kill people you feel quite evil and quite horrible as a person and to just have somebody saying "well no you, it's not you that's evil it's the voices" [...]so I didn't feel quite as bad about myself.

Participants described the experience of sharing positive qualities with other group members in the group, and their surprise at the positive feedback they received. Receiving feedback provided participants with an alternative view of self to the one often presented by their voices. As a result, group members were again encouraged to reconstruct views of themselves and develop a more balanced self-identity. Jason described developing a more balanced view of himself:

People have good points and bad points. [...] And even though the voices don't really – they tell me about my bad points, I've still got good points as well. [...] And it's ... trying to remember those good points.

Relating to others

Prior to therapy many participants described feeling isolated in their experience and avoided socializing. Engaging socially in the therapy group and receiving positive feedback from group members had a positive impact on participants' social confidence.

For many, the process of universality and the feeling of safety within the group gave group members a positive experience of talking to others, which they were able to model outside of the group. Indeed, some participants said that their ability to talk to others about their experiences outside the group had developed. Some group members also described feeling more able to accept, or feel worthy of, support from others through removal of the blame associated with hearing voices. Thus the establishment of a positive sense of self enabled some participants to be ready to accept relationships with other people. By talking to others about their (often distressing) experiences outside of the group, group members described positive changes to their personal relationships and feeling less isolated in their experience of hearing voices.

Rachael described this:

I found my relationship with my boyfriend a little better. [...] I had it out with him one day, I said that, you know he didn't listen to me and, you know he wasn't listening to me, you know, you know my experiences enough, you know he's supposed to be my carer but he wasn't listening to me enough. So we had a really good discussion one night and er, I told him all about, er, um, we discussed, um, I was abused as a little girl, sexually abused and I talked this out with Danny and um, we really had a good conversation about it. And I told him all about the hallucinations and how they affected me, what I'm seeing and, er,

I found that I've got a little closer to him, I'm a little closer with him now and I feel that, not so frightened to talk to him about things, you know, if I have a bad day what I'm experiencing and, you know.

The development of increased strength and power over voices also appeared to be generalised to social situations, where some participants talked about becoming more assertive about expressing their needs. For others, the use of mindfulness, and the positive impact this had on reducing voices and anxiety, made group members feel better able to concentrate on conversations with others and engage socially with them. As a result, participants described a shift from seeing themselves as an isolated individual, whose social identity was defined by their voices, to a person who was 'open' to socializing with others. Patricia described this:

I think when I go to the group it changed dramatically, I wanted to go out, I wanted to meet people and be, you know, interested in people.

Through developing a social identity, group members described changing their socializing behaviour outside of the group context. For example, a number of participants talked about remaining in contact with other group members, and arranging to meet up socially or speak to each other on the phone. Others talked about improved socialization with family members or friends, as Anna described:

Um, I think I'm more –more open at the moment. [...] I tend to talk to people a lot more. [...] Whereas before I- I was quite reclusive before. Now I'm sort of like, I go to my parents quite often, which is something I didn't do before. [...] And I tend to phone my mum quite a lot now, so. I, I go out with friends a lot more. [...] Which is again something I didn't do before.

However, all participants did not share this motivation for continued socializing. Some group members described a sense of fragility around their social-identity as being dependent on the

group. As a result, once therapy groups had finished these participants felt that their social support network had been taken away, therefore reducing their motivation for continued socializing.

DISCUSSION

Three therapy-specific themes emerged from a qualitative exploration of participants' experience of PBCT groups for distressing voices: relating differently to self (developing a separate identity to one dominated by voices and developing a positive view of self), relating differently to voices (through developing mindfulness skills and through challenging the strength and power of voices) and relating differently to other people.

Relating differently to Self

People experiencing psychosis are likely to hold negative beliefs about themselves. This may be particularly true for people distressed by hearing voices (Close & Garety, 1998) and low self esteem has been found to act as an independent contributor to depression in voice hearers (Fannon et al, 2009). Consequently, therapeutic interventions aimed at strengthening positive self-beliefs could be of benefit. Participants in the present study noticed positive beliefs about self emerging through the therapy. This is consistent with findings of Allen et al (2009) who reported recipients of MBCT for depression to be 'valuing of self' post-therapy.

With specific reference to voice hearing, and consistent with the findings of Goodliffe et al (2010), the sub-theme of 'identity separate to voices' within the current study suggests the therapy helped participants to develop and strengthen a view of themselves in which hearing voices did not have 'master status' (Goffman, 1963), that is, a view of self not entirely dominated by hearing voices. In this way it is possible that the therapy began to reduce the influence of self-stigmatisation by helping participants to acknowledge aspects of identity beyond that of someone who hears voices.

Relating Differently to Voices

Mindfulness practice was mentioned by most participants as allowing them to notice voices without becoming drawn in. This corroborates previous research that found 'voices were allowed to come and go without struggle' after participants engaged with mindfulness practices (Abba et al, 2008). Changed beliefs about voice power and strength were also identified. Some participants made a link between developing mindfulness skills and learning, through mindfulness practice, that voices had less power and strength than they had previously realised – again, linking to Abba et al (2008) who reported a main category of 'reclaiming my power through mindfulness practice and acceptance'. Other participants did not make an explicit connection between mindfulness practice and changed beliefs about voices. Rather, they noticed that by not responding to voice comments and/or not obeying voice commands that their previous beliefs about voice strength and power were weakened. This fits with traditional cognitive theories of psychosis, in which beliefs about voice power and control are seen to mediate the relationship between voice activity and distress – it is not voices that cause distress directly but the power and control ascribed to them (Birchwood & Chadwick, 1997).

Relating Differently to Others

People experiencing distressing psychosis often have difficulties in social relationships, and there is growing evidence that relationship patterns with people in the social world are associated with how people relate to voices (see Hayward et al, 2011 for a review).

In the current study some participants spoke of developing confidence in social situations as a result of positive experiences of talking to others within the group. Some participants also suggested that a positive sense of self enabled an acceptance of support from others within their social environments, associated with a perception of self being worthy of this support. These processes are somewhat dissimilar from those identified by Allen et al (2009) within their qualitative evaluation of experience of MBCT for depression. They too reported a theme about

'improved relationships', but attributed these improvements to processes that enabled participants to relate more healthily to others. This is contrasted with the experience of voice hearers within the current study who seemed to focus upon processes that enabled them to be the recipients of the healthy relating of others. In both studies the outcome of improved relationships was the same, as was the likely influence of a more positive/valued sense of self. The difference concerns the direction of relating (a self-to-other focus in depression, and other-to-self-focus with voice hearing), possibly reflecting the differing locus of criticism within depression (self loathing) and voice hearing (other - derogatory voices).

Clinical Implications

The findings of the current study suggest that each of the four domains of the PBCT model are important in facilitating change. Changed beliefs about voice strength and power emerged as a sub-theme in the analysis as facilitating change and thus the PBCT domain of symptomatic meaning is supported by the current study. The second domain of changing schema is also supported by findings from the current study. Schema-change was noted in themes concerning increased positive sense of self and the redefining of self as separate from voices. Improved social relationships also indicate possible change in beliefs about others. In contrast to Goodliffe et al (2010) participants mentioned mindfulness practice and principles as an important aspect of the therapy, supporting a role for the domain of 'relationship with internal experience'. There was also evidence that participants were moving from having a fixed and negative sense of self, towards developing a different conceptualisation of self as one that is fluid, changing and contradictory, therefore providing some tentative support for a role of the final domain of 'symbolic self'.

Limitations and Conclusions

The first author, had their research supervised and validity checks conducted by members of the research team, inevitably influencing the analysis. With hindsight the analysis may have

benefitted from being supervised and validity checked by independent researchers and who were naïve to the therapy model. However, the quotations used to illustrate each sub-theme enable the reader to ascertain the potential influence of the researchers on the analysis. Only 10 of 23 therapy completers were included in this study, it is possible that these 10 participants were not representative of all completers - they possibly found the therapy more beneficial than the 13 people who did not participate.

The therapy groups in this study were refined in response to Goodliffe et al's (2010) failing to find corroboration for the 'relating to internal experience' domain of the PBCT model. The current study has provided support for all four domains of the PBCT model. As with Goodliffe et al (2010), findings of the current study will inform further refinements of PBCT. This is in line with Berry and Hayward (2011) who recommend that CBT for psychosis may be improved through being informed findings of qualitative studies of participant experiences.

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