

## Brief Coping Strategy Enhancement for distressing voices: an evaluation in routine clinical practice

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**BEHAVIOURAL AND  
COGNITIVE PSYCHOTHERAPY**



**Brief Coping Strategy Enhancement for distressing voices:  
an evaluation in routine clinical practice**

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**Abstract**

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6 Background – hearing voices can be a common and distressing experience. Psychological  
7 treatment in the form of Cognitive Behaviour Therapy for Psychosis (CBTp) is effective, but  
8 is rarely available to patients. The barriers to increasing access include a lack of time for  
9 clinicians to deliver therapy. Emerging evidence is suggesting that CBTp delivered in brief  
10 forms can be effective and offer one solution to increasing access.  
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17 Aims – we adapted an existing form of CBTp, Coping Strategy Enhancement (CSE), to focus  
18 specifically on distressing voices in a brief format. This intervention was evaluated within an  
19 uncontrolled study conducted in routine clinical practice.  
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24 Methods - This was a service evaluation comparing pre-post outcomes in patients who had  
25 completed CSE over four sessions within a specialist outpatient service within NHS Mental  
26 Health Services. The primary outcome was the Distress scale of the Psychotic Symptoms  
27 Rating Scale – Auditory Hallucinations (PSYRATS-AH).  
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33 Results – data were available from 101 patients who had completed therapy. A reduction  
34 approaching clinical importance was found on the PSYRATS distress scale post-therapy  
35 when compared to the baseline.  
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40 Conclusions – the findings from this study suggest that CSE, as a focussed and brief form of  
41 CBTp can be effective in the treatment of distressing voices within routine clinical practice.  
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44 Within the context of the limitations of this study, brief CSE may best be viewed as the  
45 beginning of a therapeutic conversation and a low-intensity intervention in a stepped  
46 approach to the treatment of distressing voices.  
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## Introduction

The experience of hearing voices is reported by 70% of patients with a diagnosis of Schizophrenia Spectrum Disorder (Thomas et al., 2007) and is also common in other psychiatric diagnoses, e.g. Borderline Personality Disorder (Sommer et al., 2012). This experience can have a devastating effect on patients' lives due to high levels of distress (Birchwood & Chadwick, 1997), depression (Birchwood et al., 2004) and an increased risk of suicide (Kjelby et al., 2015).

Cognitive Behaviour Therapy for Psychosis (CBTp) for the treatment of the 'positive symptoms' of schizophrenia, including distressing voices is recommended in international best practice guidelines.(Kreyenbuhk et al., 2010; National Collaborating Centre for Mental Health, 2014). CBTp has beneficial effects on voices with a small-medium effect size (Hedges  $g=0.44$ ) (Van der Gaag, Valmaggia, & Smit, 2014). However, there are severe implementation challenges (van der Gaag, 2014) and access in the National Health Service in the UK is extremely limited with only 10% of patients who could benefit getting access to the therapy (Schizophrenia Commission, 2012). The barriers to increasing access include a lack of time for clinicians to deliver therapy (Haddock et al., 2014). Coping Strategy Enhancement (CSE, TARRIER, 1992) is a form of CBTp that has the potential to increase access due to its brevity. Furthermore, as a practical therapy focused upon behaviour change it may be deliverable by a wide range of clinicians including those with limited therapy experience.

The majority of hearers report one or more strategies used to 'cope' with voices (Farhall, Greenwood, & Jackson, 2007), suggesting most take actions of their own volition to cope with voices they appraise as a threat or challenge. Descriptively, these coping actions can be grouped (Tsai & Chen, 2006) into domains of: *Doing something* (Behavioural), e.g. such as a chore; *Thinking differently* (Cognitive), e.g. telling myself not to worry; and, *Changing*

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3 *sensations* (Physiological), e.g. having a shower. Most strategies are not specific to one's  
4 culture, although there are some reported cross-cultural differences in emphasis (Loue &  
5 Sajatovic, 2008).  
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10 Given the range of possible strategies for coping with voices, the hearer's view of what  
11 works for them is a key perspective that may facilitate therapeutic engagement. This was the  
12 rationale of Tarrier and colleagues when they developed CSE. This approach was premised  
13 upon a functional analytic model in which triggers and reactions to psychotic experiences  
14 would influence the probability of their re-occurrence. The assumption was that patients had  
15 an existing repertoire of helpful coping strategies (i.e. strategies that targeted triggers and  
16 reactions), however the effectiveness of them was limited by their inconsistent and non-  
17 strategic application.  
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27 CSE was developed as a 10-session therapy for the broad range of psychotic symptoms and  
28 participants reported reductions in symptom severity within case studies (e.g. Tarrier,  
29 Harwood, Yusopoff, Beckett & Baker, 1990). Findings from a Randomised Controlled Trial  
30 (RCT) also showed improvements on measures of the number and severity of psychotic  
31 symptoms, but a more detailed analysis of separate symptoms suggested that this  
32 improvement was more evident for delusions than for voices (Tarrier et al, 1993). The  
33 authors suggest that this differential symptom response may have been attributable to  
34 issues of measurement, and they reported no evidence that voices responded less well  
35 when CSE was included as part of an integrated CBT package in a subsequent RCT (Tarrier  
36 et al, 2001). CSE has not subsequently been robustly evaluated as a stand-alone  
37 intervention for psychotic symptoms, leaving these issues unexplored. In the light of recent  
38 evidence suggesting that the effects of CBTp can be enhanced when focused upon a single  
39 symptom (Mehl, Werner & Lincoln, 2015), what might be the effects of CSE targeted  
40 exclusively upon voices?  
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3 We adapted CSE into a brief (4 session) intervention targeted specifically at distressing  
4 voices that could be delivered by a range of mental health practitioners as part of routine  
5 clinical practice. Voice-related distress was chosen as the primary outcome as it is the focus  
6 of the cognitive model of voices (Chadwick, Birchwood & Trower, 1996), is recommended as  
7 a therapeutic target by NICE (National Collaborating Centre for Mental Health, 2014), and is  
8 important to patients (Greenwood et al, 2010; Meddings & Perkins, 2002). This was an initial  
9 uncontrolled evaluation investigating the hypothesis that brief CSE would lead to a post-  
10 treatment reduction in voice-related distress.  
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## 20 **Method**

### 21 Study design

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23 This was a service evaluation comparing pre-post outcomes in patients who had completed  
24 all four CSE sessions. Routine clinical data was collected at the baseline assessment (pre-  
25 CSE) and at the post-CSE assessment by Research Assistants not involved in therapy  
26 delivery. As this was a service evaluation analysing data from routine clinical practice, no  
27 ethics approval was required (Department of Health, 2005).  
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37 Patients were receiving a secondary care service within a single NHS Mental Health Trust in  
38 Sussex, UK. They were referred to the Voices Clinic, a specialist outpatient service for  
39 people distressed by hearing voices, irrespective of diagnosis. Eligibility criteria for the  
40 Voices Clinic required that patients scored at least 4 on the P3 item ('hallucinatory behaviour  
41 - hallucinations occur frequently but not continuously, and the patient's thinking and  
42 behaviour are affected only to a minor extent') of the Positive & Negative Symptom Scale  
43 (PANSS; Kay, Fiszbein & Opler, 1987) and at least 3 on one of the distress items  
44 ('intensity of distress' and 'amount of distress') of the Psychotic Symptoms Rating  
45 Scale – Auditory Hallucinations Scale (PSYRATS – AH; Haddock et al, 1999).  
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56 Diagnosis was not an inclusion criterion. Between May 2014 and February 2017, 158  
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3 patients were offered CSE therapy and at the time of this report: 3 (2%) were waiting  
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5 for therapy to begin, 5 (3%) were currently receiving therapy and 37 (23%) had  
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7 dropped out. A total of 113 (72%) patients completed therapy, of whom 101 (64%)  
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9 had also completed the post-therapy assessment.  
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### 11 12 13 Intervention

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15 The CSE treatment consisted of a maximum of four hours (of up to one hour, offered  
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17 approximately weekly) of individual therapy, guided by a therapy protocol and patient  
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19 workbook (copies available from the first author on request).  
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#### 22 *Session 1:*

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25 A semi-structured interview (adapted from the Antecedent & Coping Interview, Tarrier et al,  
26  
27 1990) was used to identify the antecedents to voice activity, and the patient's emotional and  
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29 behavioural responses to the voices. This stimulated a process of identifying coping  
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31 strategies and evaluating their effectiveness.  
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#### 34 *Session 2:*

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37 An existing coping strategy was collaboratively selected and considered in detail.  
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39 Discussions focussed upon how the strategy could be modified and used differently (more or  
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41 less often). A plan was agreed to implement the strategy between sessions.  
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#### 44 *Session 3:*

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47 Implementation of the modified coping strategy was reviewed. Discussions focussed upon  
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49 the enablers and barriers to implementation, and the effectiveness of the strategy. This  
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51 strategy could be further modified to enhance effectiveness, or another strategy could be  
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53 selected and modified. A plan was agreed to implement the strategy between sessions.  
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#### 56 *Session 4:*

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3 Implementation of the modified coping strategy was reviewed, and any required  
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5 modifications were agreed. Plans were discussed for continued implementation post-  
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7 therapy. Discussions explored any learning from therapy in relation to both self and voices,  
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9 and the implications of this learning for living well with voices. Any needs for further therapy  
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11 were discussed.

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14 Therapy was provided by clinicians with varying experience of delivering therapy to people  
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16 distressed by hearing voices. There were 26 therapists in total: 34 (34%) patients were seen  
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18 by a clinical psychologist; 36 (36%) by a clinical/counselling psychology trainee; 28 (28%) by  
19  
20 a mental health nurse or occupational therapist; and 3 (3%) by a CBT therapist. Therapists  
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22 were taught to deliver CSE during a 90-minute training session facilitated the by the first  
23  
24 author who also provided monthly supervision.

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27 All patients were receiving treatment-as-usual from their mental health teams during the  
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29 course of the study. Treatment-as-usual consisted of regular outpatient appointments with a  
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31 consultant psychiatrist, psychotropic medication and regular contact with clinical care team  
32  
33 members.

### 34 35 36 Assessment and measures

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39 Patients were assessed by a Research Assistant not involved in delivering therapy (in order  
40  
41 to reduce risk of bias) at two time points: 1) Baseline - within four weeks before starting  
42  
43 CSE; and 2) Post-therapy - within four weeks of finishing CSE. Baseline assessments  
44  
45 included the collection of demographic information. Diagnostic information was verified by  
46  
47 the treating psychiatrist. The study used the following clinical outcomes:

#### 48 49 50 *Primary clinical outcome*

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53 Psychotic Symptoms Rating Scale – Auditory Hallucinations (PSYRATS-AH) - an 11-item  
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55 rating scale designed to measure the severity of different dimensions of voice hearing. Each  
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57 item is rated 0-4, with higher scores indicating more difficulty. The four factor version of the  
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3 scale groups the items together as: distress (negative content, distress, and control;  
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5 subscore range 0-20), frequency (frequency, duration, and disruption; subscore range 0-12),  
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7 attribution (location and origin of voices; subscore range 0-8), and loudness (loudness item  
8  
9 only; range 0-4) (Woodward et al., 2014). The 5-item distress scale was the primary  
10  
11 outcome measure and is reported to be reliable (intraclass correlation coefficient = 0.93).

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14 The minimally clinically important difference (MCID) can be used as a reference point to help  
15  
16 establish whether or not any pre-post treatment change is meaningful or not. A reduction of  
17  
18 3 points on the PSYRATS distress scale can be used as a primary indicator of change for  
19  
20 patients. When interpreting the 95% confidence intervals around the pre-post treatment  
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22 effect size, we are interested in seeing to what extent the true effect could be smaller or  
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24 larger than the MCID threshold as well as whether it is non zero.

#### 25 26 27 *Secondary clinical outcomes*

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30 PSYRATS – AH Frequency subscale (described above).

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33 Choice of Outcome in CBT for Psychoses (CHOICE) – short-form – a 12-item form of the  
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35 34-item self-report questionnaire developed with patients to assess goals for CBT for  
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37 psychosis that are relevant to subjective recovery (Greenwood et al., 2010). Eleven items  
38  
39 are related to the therapy to create a severity score and 1 item is a free text item where  
40  
41 respondents can insert their personal goal. All items are rated by patients on a 0-10 scale (0  
42  
43 = worst, 10 = best). The short version was developed specifically for the IAPT-SMI initiative  
44  
45 (Jolley et al, 2015), based on the highest loading items from the 34-item measure. Inter-  
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47 rater, internal, and test-retest reliability for the new measure are all good, as is criterion  
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49 validity (Greenwood et al., 2012).

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52 *DASS-21* – a 21 item self-report questionnaire measuring depression (7 items), anxiety (7  
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54 items) and stress (7 items). Patients rate on a 0-3 scale how much a statement applies to  
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56 them over the past week (0 = do not apply to me at all, 3 = applies to me very much/most of  
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3 the time). DASS-21 has excellent internal consistency and concurrent validity (Antony,  
4 Bieling, Cox, Enns, & Swinson, 1998) and adequate construct validity (Henry & Crawford,  
5 2005).  
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10 *Short Warwick Edinburgh Mental Well-being Scale (SWEMWS)* – a 7 item self-report  
11 questionnaire measuring mental well-being. Patients rate on a 1-5 scale how much a  
12 statement (e.g. I've been feeling useful) applied to them over the past two weeks (1 = none  
13 of the time, 5 = all of the time). SWEMWS has adequate reliability (Stewart-brown, 2008)  
14 and external construct validity (Bartram, Sinclair, & Baldwin, 2013).  
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### 21 *Statistical analysis*

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24 Patient characteristics and clinical outcomes were summarised using descriptive statistics:  
25 count (n), percentage (%), mean (m), standard deviation (sd) and range. For each clinical  
26 outcome measure with <75% missing items, the assumption of Missing at Random (MAR)  
27 was applied and multiple imputation using chained equations (MICE) was used (Eekhout et  
28 al, 2013). The imputation model consisted of all pre and post items for the measure and  
29 patient characteristics (diagnosis, age, gender, employment status, marital status, ethnic  
30 group and education) were included as auxiliary variables. Items were treated as  
31 continuous variables. Ten imputations were used for each model. For each model, total pre  
32 and post scores were calculated and then compared using paired sample t-tests on n-1  
33 degrees of freedom as the primary analysis where the pre-post difference ( $m_{diff}$ ) is the  
34 unstandardised effect size. The standardized effect size was calculated as Cohen's  
35  $d = t_c [2(1-r)/n]^{1/2}$  where  $t_c$  is the test statistic for correlated observations and r is the pre vs  
36 post score correlation  
37  
38 (Dunlap et al., 1996). As a secondary analysis, a complete case analysis was carried out  
39 using paired sample t-tests after first being satisfied that the distribution of  $m_{diff}$  met the  
40 Normal criteria (Altman, 1991). If this was violated, bootstrapping was used to estimate the  
41 bias corrected accelerated (BCa) 95% confidence intervals. Results from the complete  
42 analysis were then compared to the multiple imputation model results as a sensitivity  
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3 analysis. No attempts were made to correct for multiple testing because a primary outcome  
4 had been selected a priori and analyses of all other secondary outcomes were considered  
5 exploratory. All tests were significant at the 5% level. All analyses were carried out using  
6 STATA version 13.  
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## 10 11 12 **Results** 13

14 Data from a total of 101 patients who had attended 4 sessions of CSE and so received the  
15 full course of therapy were eligible for inclusion in this service evaluation. By individual  
16 outcome, the CHOICE goal rating had the highest level of missing paired data (n=37; 37%);  
17 this was due to the assessor not having the baseline goal information at the post-therapy  
18 assessment and the client not being able to recall their goal. Levels of missingness of pairs  
19 on the other total scores were as follows: SWEMWBS (n=21; 21%), CHOICE Severity (n=17;  
20 17%), Distress (n=21; 21%), Stress (n=17; 17%), Anxiety (n=16; 16%), Depression (n=16;  
21 16%) and Frequency (n=17; 17%). Across all 48 items and 101 patients, there were 4,848  
22 data points of which 5.4% were missing at baseline and 16.3% missing at post treatment.  
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33 The demographic and clinical characteristics of the study sample can be found in Table 1.  
34 The sample was atypical as a significant majority (59%) of the patients had a non-psychotic  
35 disorder and the majority (52%) were female. With respect to other patient characteristics,  
36 the sample was similar to other studies of CBTp: mean age of 39 years ranging from 18 to  
37 67 years; 69% unemployed; 60% single; and 97% currently prescribed psychotropic  
38 medication. With regard to ethnicity, 87% were White British or White Other which  
39 is representative of the geographical region.  
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TABLE 1 ABOUT HERE

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3 Data was imputed for 33 (12.5%) and 52 (6.6%) missing item responses at baseline and post  
4 therapy, respectively. Our primary analysis demonstrated improvement on the PSYRATS  
5 distress scale post-therapy when compared to the baseline (see Table 2). The mean change  
6 post-therapy was -1.7 (95% CI -2.80, -0.65) points on the subscale with the MCID of -3  
7 points sitting on the margin of the lower boundary of the 95% confidence interval. This was a  
8 small-medium effect size of  $d=0.39$ . The results also indicate promising levels of  
9 improvement on a number of the secondary outcomes with a large effect for CHOICE goal  
10 rating of 2.4 points (95% CI 1.62,3.22;  $d=0.74$ ), and small effects sizes for CHOICE severity  
11 mean of 0.7 points (95% CI 0.36,0.94;  $d=0.34$ ), depression of -1.3 (95% CI -2.24,-0.28;  
12  $d=0.21$ ), anxiety of -1.1 (95% CI -1.87,-0.42;  $d=0.22$ ) and PSYRATS frequency of -0.8 points  
13 (95% CI -1.35,-0.23;  $d=0.31$ ). These effects were all also statistically significant. The  
14 complete case analysis yielded very similar results to the primary analysis (see Table 2 for  
15 Cohen's  $d$ , full results omitted). The two sets of results were compared as a sensitivity  
16 analysis and it was noted that: any differences were marginal, effect sizes and corresponding  
17 confidence intervals were of the same magnitude and all conclusions were consistent.  
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34 TABLE 2 ABOUT HERE  
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### 36 37 Discussion

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39 This study aimed to evaluate the impact of a single-symptom and brief form of CBTp upon  
40 the distress related to hearing voices. Most patients completed the full course of therapy,  
41 suggesting that it was acceptable to them and engaging. Statistically significant changes  
42 were found for the primary outcome of voice-related distress, albeit with a small-medium  
43 effect size, and the lower 95% confidence interval was inline with the minimum clinically  
44 important difference. These changes were accompanied by small effect sizes for reductions  
45 in secondary measures of emotional distress (anxiety and depression) and voice frequency.  
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3 greatest benefit reported in relation to the patients' personal goals (a large effect). These  
4 findings are encouraging in the context of the real-world clinical environment within which  
5 the therapy was delivered by a range of mental health practitioners.  
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9 These findings add to the evolving literature suggesting that CBTp can delivered in a single  
10 symptom and mechanism-focused format (Van Der Gaag, Van Oosterhout, Daalman,  
11 Sommer, & Korrelboom, 2012) (Freeman et al., 2015). Whilst brief CSE seeks to adapt  
12 coping strategies, any increase in the effectiveness of these strategies may influence the  
13 client's appraisals of self and voices, mechanisms that have been shown to be associated  
14 with emotional distress (Fannon et al, 2009). Given the key importance of distress reduction  
15 to patients (Greenwood et al., 2010; Meddings & Perkins, 2002) and commentators (Kuipers,  
16 Onwumere, & Peters, 2016), and evidence that it has not consistently been reduced by  
17 CBTp (Mawson, Cohen & Berry, 2010), the changes on the primary outcome were  
18 encouraging and suggest that researchers should seek to foreground the measurement of  
19 voice-related distress in future trials. This study also corroborated the suggestions from a  
20 recent review (Naeem et al., 2016) and meta-analysis (Hazell et al, 2016) that CBTp can be  
21 effective when offered over timeframes that are shorter than the 16 sessions recommended  
22 by NICE.  
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### 39 **Limitations**

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41 Several words of caution are required in relation to the current study. Firstly, the evaluation  
42 was uncontrolled and the benefits may have occurred naturally over time. A future study of  
43 this adapted form of CSE would benefit from having a randomised controlled design to allow  
44 hypotheses of effectiveness to be tested directly. Secondly, the absence of follow-up data  
45 provides no indication of the extent to which benefits might have been sustained after  
46 therapy. This is another question for future research.  
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### 55 **Clinical implications**

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3 CSE could be evaluated in a future randomised controlled trial as a standalone brief  
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5 intervention with the intention of increasing access to CBTp for patients distressed by  
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7 hearing voices. This would facilitate further evaluation of the relative merits of an intervention  
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9 that could be made widely available (due to its brevity) but may only have modest effects.  
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11 Alternatively, the modest and uncontrolled effect sizes within the current study can be  
12  
13 interpreted as indicating that sustainable recovery may be more likely to occur if brief CSE  
14  
15 were offered as an accessible and engaging 'low intensity' intervention offered by a range of  
16  
17 mental health practitioners within a stepped care model (Waller et al, 2013). Following brief  
18  
19 CSE, if patients remain distressed, the next step could be informed by patient preference,  
20  
21 and potentially include longer and more complex ('high intensity') therapies such as  
22  
23 Mindfulness-based group therapy (Chadwick et al., 2016), Relating Therapy (Hayward,  
24  
25 Overton, Dorey, & Denney, 2009), Avatar Therapy or Cognitive Therapy for Command  
26  
27 Hallucinations (Birchwood et al, 2014), delivered by highly trained therapists.

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29  
30 A final noteworthy finding concerns the large effect for the personal goal within the CHOICE  
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32 measure. Many of the patients took this opportunity to articulate a change that had particular  
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34 meaning to them, and for many patients (32%) the goal was not explicitly related to voices  
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36 (e.g. to be more creative, to go out more, to feel better in myself). At a time when there  
37  
38 continues to be debate about what should be measured to capture change in relation to  
39  
40 distressing voices (e.g. distress, quality of life, impact on daily activities) (Thomas et al.,  
41  
42 2014), in addition to measuring distress as a primary outcome, we should ask each patient  
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44 to express their views and ensure that this goal is foregrounded and regularly evaluated  
45  
46 within therapy.  
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**Table 1: Demographic and clinical characteristics of patients**

<b>Characteristics</b>	<b>Total n = 101</b>
Mean age in years (SD, range) <b>Gender</b>	39 (11, 18-67)
<b>\$</b>	
Males	48 (48%)
Females	52 (52%)
<b>Ethnicity</b>	
White British or white other	88 (87%)
Black and Minority Ethnic	13 (13%)
<b>Marital status</b>	
Single	61 (60%)
Married/cohabiting/long term relationship	26 (26%)
Widowed	4 (4%)
Separated/divorced	10 (10%)
<b>Employment</b>	
Unemployed	70 (69%)
Full time/part time paid employment	16 (16%)
Student	6 (6%)
Home maker	3 (3%)
Other	6 (6%)
<b>Diagnosis</b>	
Non-psychotic disorder	60 (59%)
Psychotic disorder	41 (41%)
<b>Medication<sup>\$</sup></b>	
Yes	94 (97%)

Note: Percentages are based on all available data for the variable; \$=Data missing for characteristic: Gender (n=1); Medication (n=4).

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**Table 2: Pre and post treatment descriptive statistics and paired sample t-test results with standardised effect sizes**

Outcomes	Pre CSE			Post CSE			Paired sample t-test results							Complete Case	
	n	m	sd	n	m	sd	Correlation (r)	Unstd Effect Size (m <sub>diff</sub> )	SE (m <sub>diff</sub> )	m <sub>diff</sub> 95% CI	t-paired (tc)	p-value (p)	Std Effect size (d)	Std Effect size (d)	
<b>PSYRATS-AH</b>															
Distress total	93	16.1	3.7	85	14.2	4.6	0.35	-1.73	0.54	-2.8,-0.65	-3.18	0.002	-0.39	-0.37	
Frequency total	97	9	2.4	85	8	2.6	0.45	-0.79	0.28	-1.35,-0.23	-2.790	0.006	-0.31	-0.39	
<b>DASS-21</b>															
Depression total	95	13.2	5.8	85	12.1	6.3	0.71	-1.26	0.49	-2.24,-0.28	-2.560	0.012	-0.21	-0.21	
Anxiety total	95	11.1	5.2	85	10.2	5.4	0.80	-1.14	0.36	-1.87,-0.42	-3.130	0.002	-0.22	-0.22	
Stress total	94	13.1	5	84	12.5	4.6	0.67	-0.76	0.42	-1.6,0.07	-1.82	0.073	-0.16	-0.16	
<b>CHOICE-SF</b>															
Severity mean	98	3.9	1.9	84	4.5	2	0.76	0.65	0.14	0.36,0.94	4.48	<0.001	0.34	0.34	
Goal rating	90	2.9	2.3	68	5.3	2.4	0.27	2.42	0.39	1.62,3.22	6.13	<0.001	0.74	0.91	
<b>SWEMWBS</b>															
SWEMWBS Total	91	18	4.7	83	18.6	4.9	0.63	0.39	0.46	-0.53,1.32	0.85	0.398	0.08	0.10	

Note: Full sample N = 76. PSYRATS-AH = Psychotic Symptoms Rating Scale – Auditory Hallucinations, DASS-21 = Depression, Anxiety and Stress Scale-21, CHOICE-SF = Choice of Outcome in Cognitive Therapy for Psychosis Scale (short form), SWEMWBS = Short Warwick-Edinburgh Mental Well-Being Scale. Unstd = Unstandardised, Std = Standardised. Paired sample t-test results and corresponding standardised effect sizes based on multiple imputed data to account for missing data. Complete case analysis based only on non-missing data.