

# Cognitive behavioural therapy group work with voice hearers. Part 1

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## Abstract

This study presents a small, randomized control trial of cognitive behavioural interventions within a group setting for the treatment of auditory hallucinations. In a sample of 20 voice hearers, 10 were randomly allocated to an eight-session cognitive behavioural therapy group, and 10 underwent psychiatric 'treatment as usual'. Baseline assessments were undertaken. Measures of control, power, frequency, and symptoms of distress and anxiety, were recorded on assessment and on completion of the group. The groups achieved a significant reduction in frequency of auditory hallucinations and in the beliefs about the power of the voice. Satisfaction measures also suggested that the group participants valued the group and benefited from the structured sessions. Universality, the recognition that other people experience very similar problems, was one of the most beneficial factors of the intervention. This study suggests that group cognitive behavioural therapy was helpful in the treatment of auditory hallucinations.

**Key words:** Cognitive behavioural therapy ■ Psychiatric disorders

This is the first of two papers that present a randomized control trial of cognitive behavioural therapy (CBT) within a group setting for the treatment of auditory hallucinations. Voice hearing is a phenomenon that is widely experienced among people who use mental health services, and thus opportunities to bring people together to understand and discuss their experiences is realistic and has potential for added therapeutic value. While voice hearing is the focus of extensive study, including CBT, there is little reported experience of using various methods within a group-based approach. This study has used a well-

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established CBT intervention programme within a group-based approach to determine whether the CBT effect on the voice-hearing experience remains effective and whether there are additional benefits.

## Voice hearing literature

Tien (1991) found that hearing voices was more common than expected. In a survey of 15 000 members of the general population, he found that there was a prevalence rate of 2.3%. In Tien's study only one-third of clients experiencing auditory hallucinations reported distress or impairment of functioning, at a significant enough level to meet the criteria for a psychiatric diagnosis. Romme and Escher (1989) have researched a non-psychiatric population, and a more recent review of the literature by Van Os (2003) provided substantial evidence that voice hearing was not found exclusively within the psychiatric population.

## Distress

However, it is clear from clinical and empirical evidence that voice hearing can be distressing (Garety and Hemsley, 1987). Voice hearing, referred to as auditory hallucination in psychiatry, is a diagnostic factor in mental illness, and in particular schizophrenia (American Psychiatric Association, 1994). While developments in neuroleptic medication have led to improvements in the management of voices as psychotic symptoms, a significant number of people still experience distressing auditory hallucinations, and a considerable number do not respond to medication (Whitaker, 2004; Lieberman et al, 2005; Ganguli and Strassing, 2006). Distressing symptoms might be a factor in the development of depression, anxiety, low self-esteem and social isolation, and these secondary experiences are usually the cause for seeking help.

Earlier studies by Meichenbaum (1977) and Slade and Bentall (1988) focused on the management of residual psychotic symptoms and the concept of stress inoculation training with the aim of increasing a client's coping skills, thereby helping to reduce the impact of specific symptoms and aid the client in tolerating the problems. Fowler and Morley (1989) established that affective reactions, such as loss of hope and poor understanding of difficulties, were of equal importance. Hence, determined efforts were made to create a more flexible, empathetic and collaborative therapeutic approach.

Kingdon and Turkington (1977) highlighted the effectiveness of individual CBT in treating positive symptoms of drug-resistant schizophrenia, illustrating how this concept

has been increasingly understood and utilized over the years. Birchwood and Tarrrier (1992) discuss strategies to control distressing symptoms such as auditory hallucinations. Such interventions have usually been delivered to individuals and families, rather than groups with similar experiences.

Romme and Escher (1989) who, when they used differing sampling methods to study hallucinations in clinical and non-clinical groups, found that people's ability to cope with voice hearing varied according to their own appraisal. They found diverse emotional and behavioural reactions which depended on the content of the voices.

It is now known that much of the distress associated with auditory hallucinations arises from the individual's beliefs about voices rather from the experience itself. Specifically, it has been demonstrated that the degree of fear associated with hearing voices is mediated by beliefs regarding the omnipotence and omniscience attributed to the voices. Chadwick and Birchwood (1995) found these beliefs to be ubiquitous. They also found that all clients involved in their study viewed voices as being extremely powerful (omnipotent). Some 73% reported collateral symptoms, such as visual hallucinations and delusions of control, which supported their beliefs about the voices. Where the voice was perceived as persecutory or malevolent then the voice was resisted and evoked anger and despair, whereas benevolent voices were seen as advisory.

### Content of the voices

The content of the voices also appears to be important, particularly in the case of commands to self-harm where a consideration of content seems to be paramount (Beck-Saunders et al, 1997). In line with the cognitive model, the importance of the participant's emotional reaction must not be forgotten. The study by Beck-Saunders offers preliminary support for the hypotheses that the beliefs individuals hold about their voices are important in determining whether or not they comply with the commands. Studies examining the effectiveness of individual cognitive therapy to address such beliefs have been promising (Birchwood and Trower, 2006).

Systematic investigation of a person's belief systems is necessary when carrying out CBT. Good assessment, and encouraging the client to self-monitor, is crucial to this process. Chadwick and Birchwood (1995) and Chadwick et al (2000) developed the 'Beliefs About Voices Questionnaire' to assist in the assessment of voices. This simple to use scale complements CBT as a treatment approach, again encouraging the client to self-monitor their auditory hallucinations. Frith (1992) highlighted how hallucinations have also been associated with difficulties in self-monitoring.

Bentall et al (1991) tested the ability of clients with schizophrenia to distinguish between their own and externally generated information. He showed that when high cognitive effort was required, patients who were hallucinating were more likely than others to attribute self-generated information to that of an external source after a delay of a week. This would suggest that when uncertainty prevails, they were more likely to attribute the event to an external source.

A study by Cahill et al (1996) found that when clients with positive symptoms were presented with their own voice, which had been distorted, clients showed a bias towards attributing their own voice to another person. In a follow-up study, words were introduced which were portrayed with some emotion and feeling – again to clients who were hallucinating – and it was found that when the client's own voice is distorted, the bias is significantly stronger (Johns et al, 1999). Hence, if the voice was negative and emotional in nature, rather than neutral or positive, it was attributed to someone else. The above studies on individual cognitive behavioural therapy show that voice hearers can make sense of their experience so that it becomes meaningful to them.

### Group-based intervention literature

While the benefits of group-based approaches to working with psychological distress are reported across a range of different psychiatric problems and settings, there is limited evidence for the efficacy of group CBT with schizophrenia. An exploratory study of the effectiveness of group treatment of auditory hallucinations was explored using CBT in a group setting. The results showed significant changes in all three main outcomes. There were changes in perceived power of the voices, reduction in distress, and an increase in the number of coping strategies used by participants. The effects of treatment were similar to that obtained from individual cognitive therapy, but was considerably less expensive (Wykes et al, 1999).

A study to examine the impact of group-based CBT for drug-resistant auditory hallucinations has also been undertaken. The study assessed and evaluated 22 participants with a positive outcome to suggest that group CBT weakened the voice's apparent omnipotence (Chadwick et al, 2000).

A study by Lecomte et al (2003) suggested positive outcomes for CBT groups with first episode psychosis. More recently, a study by Bechdolf et al (2005) compared clinical outcomes between 16 sessions of group CBT and group psychoeducation without significant results. The discussion focused on the cost-effectiveness rather than therapeutic potential of group work. From the above studies there seemed to be good evidence to further explore the delivery of a CBT programme within a group setting.

### Working in groups

Voice hearing can be regarded as both a social and as a psychological phenomena. Particularly among psychiatric patients, the comparing of symptoms and treatment experience is an inevitable and important part of the various forms of contact that take place in hospital or other settings. This contact can be both helpful and unhelpful, e.g. when comparing differences in medication or other therapeutic intervention. However, it is important to recognize that peer group contact, and in particular the development of people's expertise in their own experience, can be enhanced.

The Hearing Voices Network is a non-professional organization that provides opportunities for voice-hearers

**Table 1. 12 therapeutic factors of group psychotherapy**

1. Instillation of hope
2. Universality
3. Imparting information
4. Altruism
5. The corrective recapitulation of the primary family group
6. Development of socializing techniques
7. Imitative behaviour
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis
11. Existential factors

Source: Yalom and Leszcz (2005)

to meet and discuss their experiences without being labelled as psychiatric patients. The success of the network suggests that people gain benefits from such contact, and it can be reasonably asserted that many of the benefits accrue from participating in a 'normalizing' experience, where voices become accepted as part of the social environment. Focusing on the experience rather than the pathology, and enabling constructive sharing of experiences seems to be a critical component of successful intervention. For example, groups that are designed to run over a limited number of weeks can emphasize an educational, rather than psychotherapeutic approach, so that people can regard themselves and others as students rather than patients (this difference is particularly clear where the group involves non-patients). Longer term groups can similarly emphasize their social, rather than support, function.

### Benefits

Groups not only present resource-efficient solutions to service provision, but also as suggested above, can offer benefits to members that are not otherwise available when working individually or in family settings. Yalom and Leszcz (2005), in their seminal work on group based psychotherapy elicited 'therapeutic factors' that can be successfully facilitated from within a group setting (see Table 2). There is evidence to suggest that if individuals who experience auditory hallucinations can share their experiences with others, as well as listening to other 'voice hearers', feelings of isolation and distress can be reduced (Yalom and Leszcz, 2005).

In setting up the group, an important aspect of effective group working is the homogeneity of the group, so that there is sufficient recognized similarity of experience to allow meaningful engagement and sharing of experience. The value of setting up a group where voice-hearing is a common experience, is that it is such a strong point of identification that other variables such as age, gender or ethnicity become insignificant to the purpose of the group meeting. For groups to function as a unit, they require a communal sense of purpose or objective around which they can order their roles and relationships. Structuring

the task of the group allows for clear boundaries to be set in terms of the purpose of forming relationships among members, as well as facilitating ease of disengagement once the task has been completed. Leadership within groups can become a significant dynamic, but is more effectively managed where roles are clear and activities from week to week are structured, so that the nature of contact between group members is regulated by the task in hand.

### Method

Twenty clients diagnosed with a DSM-IV (Diagnostic and Statistical Manual) (American Psychiatric Association, 1994) diagnosis of schizophrenia who were experiencing auditory hallucinations were randomly allocated to either the experimental group (group cognitive behavioural therapy treatment), which offered an 8-week programme of cognitive behavioural therapy, or to a control group. Clients in the control group received psychiatric 'treatment as usual'. All individuals were under the care of the local mental health Trust. In all cases permission was sought from Consultant, client and Key Worker. Individual clients involved would then be formally invited to join the study via a letter. This was followed with individual client meetings to ensure they were fully aware of what the study was about and what it entailed, while giving the opportunity to answer any questions. Clients would continue with their usual treatment. The control group had routine individual follow-up. Informed consent was gained. Participants were free to withdraw from the study at any time. At the conclusion of the trial, if successful, the control group would undertake the same intervention as the experimental group. Consequently both groups would benefit from undertaking the eight sessions of group work. The group was assessed again after 6 months as it was envisaged that the benefits of the group would grow over time.

Twenty-nine people were referred from community settings, with just one inpatient. Out of the 29, 4 had benevolent voices and chose not to participate, 3 found the concept of a group too threatening, and 2 did not want to travel to the group.

### Timescale

Assessments would be carried out on two occasions (1) pre-treatment (week 0), (2) post treatment (week 12). The change between (1) and (2) would allow the measurement of the treatment effect. The total time for the two groups of eight weekly sessions and assessment would be 20 weeks.

### Measures

Baseline interviews and assessment were taken prior to the random allocation. The time scale for the individual assessments was between one and two hours depending on the needs of the client. These interviews took place at the centre where the groups were subsequently held. The independent assessors for this study undertook these assessments. There would be a pre- and post-comparison and it was hoped the benefits would build up over time. The assessments consisted of:

1. Beliefs About Voices Questionnaire (BAVQ/BAVQ-R) (Chadwick and Birchwood, 1995, 2000). This is a simple self-report questionnaire. It measures core beliefs about voices, 'malevolent' and 'benevolent', and coping strategies of 'engagement' or 'resistance'. It measures how people cope with, understand and respond to their voices.
2. Auditory Hallucinations Rating Scale (PSYRATS) (Haddock et al, 1999). This is a self-reported scale which measures emotional content, physical characteristics and cognitive interpretation.
3. The Beck Depression Inventory (Beck, 1961). Again this is a self-reported questionnaire measuring the severity of depression, from mildly depressed to severely depressed.
4. The Power Scale (Birchwood et al, 2000). This measures the power differential between the voice and voice hearer to include the constructs associated with power, including strength, confidence, respect, ability to inflict harm, superiority and knowledge. This is the voice power differential scale. Semantic differential methodology was used to construct this scale, which involved presenting an incomplete sentence to patients (i.e. 'In relation to my voice I feel...'). Each construct is measured on a five-point scale. The internal reliability of this scale (Cronbach's alpha)=0.85 (N=59) with a 1 week re-test/reliability of r=0.82 (N=25).
5. The Positive and Negative Syndrome Scale (PANNS) (Kay et al, 1987). This scale was developed and standardized for typological and dimensional assessment of schizophrenia. This 30 item, 7-point rating instrument was conceived as a carefully defined and operationalized method that evaluates positive, negative and other symptom dimensions on the basis of a formal, semi-structured clinical interview and other informational resources. It can be applied in a relatively brief time and can be used for repeated longitudinal assessments.

The overall assessment took, on average, 60–120 minutes to complete by an independent assessor.

### Procedure

All participants were assessed (as previously discussed) approximately 2 weeks before commencement of their group. All group sessions were held in a local community mental health centre. The eight weekly sessions ran for one-and-a-half hours, with a break after the first 45 minutes for refreshments. The groups were closed groups, with issues of confidentiality being addressed at the start of the first session. Before their participation in this research project, participants were given a comprehensive information sheet which outlined confidentiality, how the groups would run, and that their participation was voluntary.

### Session structure and setting

The structure of the sessions was made clear, and facilitators encouraged active discussion. The sessions were client centred, with a collaborative, flexible, solution focused, here-and-now approach. Education/information giving, and anxiety management techniques were provided in the first few sessions. The general aim was to provide a structure within which group members could disclose and

**Table 2. List of group sessions and rationale**

**Rationale:**

The aim of the voices group is to raise issues of power and control while eliciting group support in improving mastery over voices.

**Session 1:**

For all participants to have a full understanding of the structure of voices group as well as their responsibility and the responsibility of the facilitators to the group.

**Session 2:**

For all participants to have an awareness of the common features of voices, and share these features with other members of the group.

**Session 3:**

All participants to examine the effects of their experiences upon their lives in a safe and structured manner.

**Session 4:**

For all participants to share all real life experiences, and ways to cope appropriately with these experiences.

**Session 5:**

To examine the beliefs about the voices power relationship with the individual, and to examine assumptions made by the voices ability to control the voice hearer, and accurately predict the future.

**Session 6:**

To increase coping strategies with the aid of group support.

**Session 7:**

To practice coping strategies within a group setting.

**Session 8:**

Further development of coping strategies and consolidation.

discuss their experiences of voice hearing and to facilitate participant's examination of their beliefs regarding the power of their voices. The rationale was to give group members the opportunity to meet other individuals who experience voices and to share their experience with others in a safe and supportive environment.

The group setting gave individuals the opportunity to try out coping strategies while experiencing their auditory hallucinations with the full support from other group members, to explore alternative explanations for their voices. This led to opportunities to explore issues of control, thereby aiding individuals to elicit how much control the voices have on their lives.

The treatment protocol has been piloted and further developed, reviewed and refined over a period of time to reach its current format. The voices group protocol utilizes coping strategy enhancement (Tarrier et al, 1990), power

and control cognitive behavioural interventions, (Chadwick and Birchwood, 1995), and CBT work (Nelson, 1997). The eight sessions were based upon a CBT approach and each session had a specific structure and format of aims and objectives. The techniques of traditional cognitive therapy, along with Socratic questioning, reflection and summarizing were used.

The first session focused on the structure of the group, ground rules and responsibilities of group facilitators and group members. The specific aim of the group was explained to all group members; this was to reduce distress that voices cause, and to increase control over voices. It was stressed to participants that the aim of the group was not to stop all voices, but to empower the voice hearer with a selection of strategies. The facilitators were keen to make it clear that the aim of the group was to help individuals to set their own achievable and realistic goals, which in turn also prevented any possibility of a situation whereby the clients would have unrealistic expectations of the facilitators and the group. A list of the group sessions, and rationale, can be seen in *Table 2*. More detailed discussion of the sessions and results will be presented in the next article. **BJN**

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## KEY POINTS

- Voice hearing is a phenomenon that is widely experienced among people who use mental health services, and thus opportunities to bring people together to understand and discuss their experiences is realistic and has potential for added therapeutic value
- Groups bring added benefits of participating in cognitive behavioural therapy.
- Opportunities for voice hearers to share experiences and coping strategies should be encouraged.
- Group work is a cost effective way of delivering cognitive behavioural therapies.
- Clients achieved a reduction in frequency of voice hearing, reduction in belief about power of voices, and increased coping strategies.