

# Cognitive behavioural therapy group work with voice hearers. Part 2

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## Abstract

This is the second of two papers that present a small, randomized control trial of cognitive behavioural therapy (CBT) within a group setting for the treatment of auditory hallucinations. In the previous paper, a method was described for an eight-session CBT group. Assessments were undertaken measuring control, power, frequency, and symptoms of distress and anxiety on commencement and on completion of the group. This second paper details the experience of the group and reports on the outcomes of the assessment measures. The study concludes that group CBT was helpful in the treatment of auditory hallucinations.

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

The first three sessions of this eight-session trial were designed to encourage engagement and promote the development of group cohesion. All members were reassured that they could talk about their voices openly. The content, distress and the individual's own beliefs about voices were explored in a group setting. No direct challenges or confrontations were made during the first three sessions. From session four the power and control of voices were examined in greater detail, and alternative explanations for voices were explored. This was facilitated by the fact that the group had by now become more cohesive.

## Explaining the voices

One of the alternative explanations given is that voices are like intrusive thoughts and are internally generated (Morrison et al, 1995). Therefore, internally generated verbal material is mis-attributed to an external force. To reinforce this concept in session five, a video showing

an individual having a tomography brain scan was used. This video demonstrated that the patient's own verbal thoughts (or inner speech) were active during the time the patient was hearing the voice (McGuire et al, 1996). This promoted further discussion and alternative explanations for voices from group members. Challenging the voice's power in the later sessions was therefore facilitated in this session, because the client's voice hearing experience was already being explored.

## Coping strategies

All participants tried new coping strategies, some of which had been recommended by other members of their group. The responses varied between helpful and unhelpful. Each client was asked to rate and score each coping strategy from 1 to 10, 10 being the optimum score. The group drew up a list of reassuring statements and positive affirmations. The clients were encouraged to make their own personal list of helpful thoughts on cue cards, to carry the cards around everyday and read them if the voices occur.

Session eight embraced further development of coping strategies, and was aimed towards each individual consolidating his or her participation in the group. A voices group feedback questionnaire was used and completed individually. At this stage friendships and trust had developed within the group, and members had noticeably become more confident and open when talking about their experiences of hearing voices, along with their various experiences of life events. Many group members expressed a desire to carry on meeting, and they discussed forming a monthly support group to continue the process of staying in control of their voices. They set a date for this, and the facilitators created a simple information sheet for the individuals.

## The groups and the individuals

To maximize participation, at the outset participants were given the option of meeting in the morning or the afternoon, leading to the experimental cohort having a morning and afternoon session. In the morning group there were three females and one male in the group. Two clients had been experiencing voices for over 20 years, one for 6 years and one for 8 years. There were four females and two males in the afternoon group. Four clients in this group had experienced auditory hallucinations for around 5 years, one client for 3 years, and another client for 2 years. During the initial session it was crucial to foster initial engagement and reduce any fear and distress.

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A simple ice-breaking exercise was used to encourage the group to bond, and information was given to group members about the eight sessions, explaining how it was hoped that they would benefit. Clients were encouraged to ask any questions they might have about the group sessions. To create confidence within the group, the facilitators reassured members that they were experienced in running such groups and gave examples of how previous clients had benefited, without breaking confidentiality. To relieve initial anxieties the facilitators used empathy and humour where appropriate.

In session two, a video of an interview of a voice hearing client was shown, demonstrating Socratic questioning and encouraging the use of coping strategies. One group member, in particular, was able to empathize with the fear and distress displayed by the patient on the video, relating it to her own experiences. She explained that she had believed that little people were living inside her head and that she was terrified of them pulling her nerves and veins apart. She was able to acknowledge that her beliefs had changed, and now realizes that these experiences were caused by her illness. Other members in the group, who were feeling hopeless about their situation, were encouraged by the process of recovery displayed by the clients in the group and video. During this session statistical information was given on voice hearing in the general population allowing participants the opportunity to put their experiences into perspective and, where appropriate, to normalize the experience.

During session three one patient described how he was feeling angry towards his voices, but he was learning to become indifferent to them and not react. Another client discussed how her voices were always quite pleasant; she would listen to them because they relaxed her. In this session clients were now demonstrating that they were understanding the concept that they might learn to exert some control over their experience of voices.

In session four the group was asked about the tricks their voices might play on them. The facilitators used an example of a voice saying something hurtful to the client, like 'their worst secret'. To illustrate this the facilitators used the analogy of 'a nosy neighbour' to highlight how it is best to be prepared for any interference, and how to be ready to exert some control by accepting this idea, but also be ready to adopt coping strategies to deal with this when it occurs.

In the fifth session, group members discussed their experiences of malevolent voices. Enabling them to reattribute the voices to negative thoughts made the experience more acceptable to clients. To take this concept further the facilitators used an analogy of dreaming, i.e. dreams can be very vivid and seem real, but when you wake up you realize it's just a dream, and not real.

In session six one client discussed how her voice, (Antecedent), was always worse at night. She believed that this was the voice of a spirit (Belief), therefore her emotions and behaviour illustrated her belief: she would panic, get out of bed, pray, and obey what the voice was saying (Consequence). Therefore, if she believed that the

voice was caused by internally generated material, i.e. her own thoughts, she would be less frightened and anxious, and consequently feel more in control. By this stage both groups had engaged quite well with other members. For example, when one client said she thought the Devil had spoken to her, another client jokingly asked her if she'd been smoking LSD. All clients were amused by this comment. Although one of the objectives of the group was to have selective contact with their voices, initially with the benevolent ones, and to use anxiety management and distraction as required, a number of participants felt that this was too threatening to do within a group. However, they were prepared to practice distraction techniques, such as stopping and naming, and attentional control. The group facilitators also noticed a relationship between perceived power of the voice and perceived power of others. Social rank and power between the individual's voice and self is strongly correlated with the perceived difference in social rank and power between self and others in the social world (Birchwood et al, 2000). A trend emerged whereby individuals who felt that others were more powerful than they were also expressed their voice to be powerful. This supports further study on the relationship between self-esteem and psychotic symptoms.

**Results**

Prior to commencement, the study was approved by both the University of Birmingham Research Ethics Committee

**Table 1. Results**

**Frequency**

The intervention led to a significant reduction in the frequency of voices, whereas no change was observed in the control group. (group x time  $f=7.0$ ,  $P<0.01$ )

	<b>Baseline</b>	<b>12 weeks</b>
Experimental:	mean 2.6 (0.7)	mean 1.4 (0.97)
Control:	mean 2.8 (0.92)	mean 2.7 (0.67)

**Perceived power**

The intervention led to a significant reduction in the perceived power of voices, whereas no change was observed in the control group. (group x time  $f=8.7$ ,  $P<0.01$ ).

	<b>Baseline</b>	<b>12 weeks</b>
Experimental:	mean 4.20 (1.0)	mean 3.30 (1.06)
Control:	mean 3.9 (0.88)	mean 4.10 (0.99)

The actual mean scores for the experimental group significantly reduced, whereas it had increased in the control group over time.

**Level of distress**

The intervention led to a trend towards the reduction in the level of distress in the experimental group, whereas this trend was less in the control group. (group x time  $f=0.07$ ,  $P<0.795$ ).

	<b>Baseline</b>	<b>12 weeks</b>
Experimental:	mean 3.20 (0.79)	mean 2.60 (1.26)
Control:	mean 2.50 (1.18)	mean 3.00 (1.33)



**Table 2. Twelve therapeutic factors of group psychotherapy**

1. Instillation of hope
2. Universality
3. Imparting information
4. Altruism
5. 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)

and the Birmingham and Solihull Mental Health Trust Ethics Committee. This ensured that participants were fully informed about the nature of the pilot study, their role, access to additional support, and their right not to participate and withdraw at any time. Furthermore, there was a clear explanation of how data would be kept and confidentiality maintained in the reporting of the study.

*Table 1* outlines a range of measures identifying the impact of the group on the individual's experience of auditory hallucination. On all indicators there was a clear benefit to the CBT over the control group for frequency, power and levels of distress experienced. This indicates that the CBT group is more effective than the treatment as usual group. There are no easily comparable data to suggest that the experimental group was less effective than treatment sessions on a one-to-one basis, but results suggest significant change in line with expectations for the methods used, as measured at follow-up week 12.

After completion of all groups, a feedback questionnaire was given to each member to evaluate their levels of satisfaction with the group. Almost all (90%) attendees stated that they found the group helpful, all had found that they felt relaxed within the group, and found it extremely helpful to share as well as listen to others' experiences of voices. All of the clients found the videos useful in helping them to look more objectively at their voice hearing. However, three participants did not actively engage with their malevolent voices during the period of attending the groups as they found the idea too distressing.

## Discussion

The results support the findings of Yalom and Leszcz (2005) that meeting others with similar experiences in a therapeutic group setting can be a key factor in achieving positive outcomes in therapy (*Table 2*). Qualitative data were obtained through the use of a satisfaction questionnaire and all the individuals who attended the experimental groups stated that they had found it helpful meeting other voice hearers. One client said that the group had been very reassuring in terms of meeting other people who could

hear voices, making her feel less isolated. Another client stated that the group had helped him to cope with his voices by understanding the experiences of other people and how they coped.

The study mirrors an exploratory study by Wykes et al (1999) in finding that groups can help clients develop adaptive coping strategies. Three clients started using a relaxation tape, four clients used personal stereos, four clients used verbal commands to tell the voices to go away, all clients began to recognize stressful life events and to plan strategies to deal with them, and four clients developed specific anxiety management techniques, e.g. breathing exercises.

Qualitative information from the independent assessments provided further details of benefits gained from the groups. Clients developed reassuring statements such as 'the voices tell lies', 'they cannot make me do something I don't want to do', 'they know a lot about me and what I am thinking, because they come from my own mind'.

Session five explored the beliefs about the voice's power relationship with the individual, and examined assumptions made about the voice's ability to control the voice hearer and accurately predict the future. In contrast to the study by Chadwick et al (2000), this was introduced earlier in the protocol, and may have had a greater influence in the reduction in the perceived power of the voice. The facilitators also felt that universality played a major role in this improvement with clients sharing and providing possible alternative explanations to the voice, as supported by Kingdon and Turkington (1991). One client attributed his voice to a poltergeist talking to him. He stated that the tone of voice was hard and frightening: 'he says he'll stick a knife in me'. Alternative explanations were generated from the group and noted on a flip chart. Explanations included, 'If it were a poltergeist, would they tell you before they stab you?' Another client suggested, 'If it were a poltergeist, why aren't things flying around the room when it talks to you?'

One client stated that: 'God talks to me and he says I must get up and read the bible'. Again, alternative explanations were generated through group discussion and written on a flip chart. One client responded: 'You are a nice person, perhaps it could be your own thoughts you are hearing aloud'. Another client suggested, 'If it was God, how come your medication reduces your voices?' It is important to note that this process would have had a reciprocal benefit to clients who were allowing their suggestions to be heard, as well as to the client receiving the alternative explanation. This process of collaborative empiricism has been shown to be extremely important in group therapy in determining positive outcomes (Yalom and Leszcz, 2005).

Another important outcome from the group was that although 9 out of the original 29 declined involvement in the group, there were no drop-outs from the course. This is worth noting, as drop out in CBT research with psychosis is common (Wykes et al, 1998). This is also supported by Nelson (1997) who states that one of the major challenges when working with people with psychosis is to get them



interested and engaged in treatment. It is envisaged that this may have been the benefit from a gentle, flexible approach, ensuring sessions were delivered in a safe, relaxing environment with sufficient time for breaks. Groups were also offered in the morning and afternoon to support those individuals who preferred certain times of the day to attend the course. This was also deemed important for clinical reasons, i.e. negative symptoms. The groups were also facilitated by two individuals trained in psychosocial interventions having over 10 years of experience working with voice hearers.

The majority of the group had heard voices for periods of five to ten years, therefore their beliefs about their voices were highly resistant to change. Consequently, if a voice-hearing group was offered as part of an early intervention package, it might significantly reduce resistance to change and beliefs about voices. Therefore, rather than seeing the voice as an 'alien', external experience over which they believe that they have no control, they become able to 'own' the voice as part of their life experience over which they can gain some control. This would have an advantageous 'knock-on' effect on other aspects with regard to quality of life, such as improved self-esteem, and reduction in anxiety and distress. Meeting in a group setting led clients to feel less stigmatized about their voices. In this sense the value of a group setting in encouraging voice hearers to talk about their voices should not be underestimated.

### Practice implications

This study shows that a group-based approach structured by use of CBT has been effective. The protocol offers a problem-centred, structured approach in which the facilitators were flexible. A slow and repetitive pace should be used, as clients who hear voices will find it very difficult to digest and understand information given to them. All clients were taking antipsychotic medication throughout the period of the study, and therefore effects may need to be attributed to the combined treatment of CBT and medication.

Clinical supervision was on-going throughout this study, and should be part of any such intervention. At the end of the eight weeks all clients who attended the

group requested a monthly support group. This has been arranged, and hopefully it will eventually be user-led.

### Recommendations for future research

A further follow-up assessment is proposed, as the literature suggests the changes in the experience of voice hearing become less significant over time, and the on-going group activities may positively influence this (Jones et al, 2004).

A larger randomized control study is needed to test the benefits of group CBT for voices, taking into account gender, the social/cultural and demographic aspects, along with differing medications that clients might be taking. Some quality-of-life measures should also be included, along with a self-esteem scale, and the use of an evaluation tool based on Yalom and Leszcz's (2005) therapeutic factors. Facilitators should be properly trained to run such groups to the specified structure and protocol. BJN

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### KEY POINTS

- All participants tried new coping strategies, some of which had been recommended by other members of their group and some of which were helpful.
- The use of humour, examples, open discussion and videos helped foster understanding and opened up group discussions.
- There was a clear benefit to the cognitive behavioural therapy group over the control group for frequency, power and levels of distress experienced, indicating that the CBT group is more effective than the treatment as usual group.
- Meeting in a group setting led clients to feel less stigmatized about their voices highlighting that the value of a group setting in encouraging voice hearers to talk about their voices should not be underestimated.