Group Mindfulness-Based Therapy for distressing voices: Increasing the availability of CBT for people experiencing psychosis

Background

Individual Cognitive Behaviour Therapy for Psychosis (CBTp) is recommended by NICE for the treatment of schizophrenia and schizoaffective disorder. Despite this, implementation of CBTp is poor, with fewer than 10% of service users with psychosis being offered the therapy. A possible solution to poor implementation might be to offer CBTp in groups, rather than individually. CBTp offered in groups appears to be similarly effective to individual CBTp, with significant medium effect sizes (Hedges g) of 0.39 and 0.42 on positive symptoms, respectively (Wykes et al., 2008). However, as the methodological rigour of the studies of group CBTp increases, the effect on positive symptoms reduces. If CBTp were to be offered in groups, refinements are necessary to increase effectiveness.

A first refinement concerns the diverse range of symptoms associated with psychosis and the possible benefit of targeting individual symptoms. Auditory hallucinations (‘hearing voices’) are experienced by approximately 70% of people with a diagnosis of schizophrenia (Thomas et al., 2007) and voices are often experienced as highly distressing and disturbing (Birchwood & Chadwick, 1997).

A second refinement is the integration of mindfulness – defined as a state of consciousness characterised by a non-judgemental and accepting awareness of present-moment experiences. Mindfulness-based interventions are typically delivered in a group format and there is emerging evidence for their potential in treating psychosis (Khoury et al., 2013).

Person-Based Cognitive Therapy (PBCT; Chadwick, 2006) combines a traditional CBTp focus on beliefs about voices, with mindfulness practice and principles and a strong experiential focus on negative and positive experiences of the self. An uncontrolled trial of group PBCT for distressing voices found significant pre-post improvements with a medium effect size on measures of global distress and disturbance (Birchwood et al., 2011). A robust evaluation of these findings within a randomised controlled study is now required.

Methods

Study design

This was a single blind, pragmatic randomised controlled trial comparing group PBCT (plus TAU) with TAU alone (TAU). The primary hypothesis stated that PBCT in comparison to TAU will lead to significant reductions in distress and disturbance in response to hearing voices. The Brighton and Sussex Research Ethics Committee (number 11/L0/1130) provided ethics approval for the study.

Measures

Blinded assessments were completed at baseline, 4 months and 10 months.

Primary Outcome

Clinical outcomes in routine evaluation-outcome measure (CORE-OM) - a 34-item scale of distress and disturbance (Evans et al., 2000).

Secondary Outcomes

PSYRATS: Auditory Hallucinations Scale (AHRS) - an 11-item rating scale measuring the severity of different dimensions of the voice-hearing experience (Haddock et al., 1999).

Hospital Anxiety and Depression Scale (HADS) – the HADS is a 14 item measure of anxiety and depression (Zigmond and Snaith, 1983).

Choice of outcome in CBT for psychosis (CHOICE) – CHOICE is a 2-dimensional 24-item self-report CBT for psychosis outcome questionnaire providing scores for severity and satisfaction (Greenwood et al., 2010).

Results

Figure 1: Flow of participants through the study.

Discussion

The effectiveness of PBCT groups for distressing voices was evaluated within a RCT. Relative to TAU, PBCT participants did not report significant improvements on the primary outcome measure of distress and disturbance. However, PBCT participants did report significant reductions relative to TAU on measures of disturbance (voice-distractibility) and disturbance (voice-control, recovery) - with the significant effect on depression maintained at six months (but lost on other measures).

There were seven hours of therapist contact per therapy completer within group PBCT (the total number of therapist hours divided by the number of patients who attended eight or more sessions) – as opposed to the sixteen hours recommended by NICE for individual CBTp. This reduced therapist time would allow more patients to be treated with the same therapist resource, thus partially addressing the accessibility issue.

The effect sizes within this study are similar to the effect sizes from trials of individual CBTp in treating distressing voices. This suggests that group PBCT may not be inferior to individual CBTp in treating distressing voices. However, this current trial was not powered to test this non-inferiority hypothesis and this is the research question for our next study.

Outcomes

Data analysis is currently in progress and a paper will be submitted for publication in a peer reviewed journal in July 2015. Preliminary analysis shows that, relative to TAU, PBCT was not different at post-intervention or six-month follow-up on the primary outcome measure (CORE).

However, PBCT did show significant benefits over TAU at post-intervention on secondary measures of distress (HADS depression, PSYRATS intensity of distress) and disturbance (CHOICE, PSYRATS voice control), although only effects on depression were maintained at follow-up.

Sample characteristics

108 participants were recruited from secondary mental healthcare services in Sussex and Hampshire (50% male; age range 18-65 years; 91% White British; 76% unemployed). All participants had a diagnosis of Schizophrenia or Schizoaffective disorder. Baseline characteristics between the two study arms were similar.

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