VOICES GROUP PROTOCOL

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Background

Despite high doses of medication a significant number of people with schizophrenia still experience distressing psychotic symptoms such as auditory hallucinations. These not only affect the quality of their lives but are probably instrumental in maintaining depression and low self esteem. The efficacy of psychological treatment as an adjunct to pharmacotherapy for these patients has been established in a number of randomised controlled trials (e.g. Tarrier et al, 1998; Kuipers et al, 1997). However, because of the dearth of trained therapists and the length of individual treatments these therapies are unlikely to become widely available in the health services in the near future. This manual describes an alternative mode of providing psychological therapy to alleviate the distress of auditory hallucinations which offers the likelihood of more general availability of psychological treatment at a lower cost.

Psychological approaches to the treatment for hallucinations have a long history. Slade and Bentall (1988) identified 40 published clinical studies which included such interventions as the wearing of earplugs, operant procedures, systematic desensitisation and thought stopping. While many of these treatments have proved beneficial to voice hearers, their effects were short lived. More recently clinicians have investigated novel psychological therapies to try to reduce the disability associated with continuing symptoms. These new approaches have all been developed from Cognitive Behaviour Therapy (CBT) which was originally devised for use with patients with depression. Three recent randomised control trials in the UK have shown that individual CBT can reduce overall symptoms and reduce relapses (Kuipers et al., 1997; Tarrier et al., 1998 Kingdom and Turkington, 1997).

However, all these approaches have had their main effect on general measures of psychopathology and except for Tarrier's study, have rarely shown effects on specific measures such as hallucination frequency or the distress associated with hallucinations. In fact Tarrier et al. (1998) have suggested that hallucinations may be more difficult to change than delusions.

Other modern studies have adopted a symptom-based approach to treatment and have specifically focussed on reducing auditory hallucinations in the long term. Two studies (Tarrier et al., 1990, 1993) have evaluated the efficacy of cognitive behavioural interventions in enhancing patient's natural strategies for coping with psychotic symptoms. Coping Strategy Enhancement (CSE) is characterised by the development of coping methods which patients may already possess as well as teaching an array of new coping strategies. Haddock et al (1993) and Bentall et al. (1994) report on a focussing approach to hallucinations. In this form of therapy patients were asked to focus on their voices and to try to reattribute the voices to themselves. Half the participants showed an improvement on this individual therapy.

Group therapy capitalises on the support of group members which can counter the widespread reports by voice hearers of social isolations (Baker, 1995). Within the group, experiences of voices can be compared allowing the commonalities between individuals to be identified which facilitates reality testing and the re-framing of the experiences. Common factors which increase the frequency and severity of the experiences can be identified which are then demystified. Finally the natural coping strategies of the group members can be shared to encourage the adoption of a wider coping repertoire.

One study has already shown that this form of treatment is feasible and potentially beneficial. Gledhill et al. (1998) in an uncontrolled study reported that all five patients said that they benefited from attending the group although only three showed any changes on the formal measures and no significance tests were carried out. A more recent waiting list controlled study (Wykes et al, 1999) showed that there were effects of group psychological therapy on symptoms, insight and distress as well as increases in the effectiveness of coping strategies adopted. Most of these improvements were still found at follow-up.

The format of group sessions briefly described here is based on a number of different approaches which have previously been shown to be successful. It draws mainly on the coping strategy enhancement approach (Tarrier et al., 1990; 1993) but also uses therapeutic elements from the normalisation approaches of Romme and Escher (1989) and CBT as formulated by Fowler et al. (1995). The main aim is to provide people in the group with an opportunity to learn new coping skills, to feel less isolated, and to raise self-esteem.

Introduction to therapy

The voices group is established for people who have strange experiences not shared by others and all sessions centre around a number of basic underlying principles. From the offset, therapy will focus on what Kingdon and Turkington (1991) called the 'normalising rational'. It will be emphasised that hearing voices is something that many people experience and that is does not mean that somebody is 'mad'. The idea of a 'continuum of experience' will also be introduced to the sessions. Here, attention will be given to a variety of experiences that may be considered 'odd' or 'abnormal', such as mysticism. As the course progresses it is suggested that the experience of hearing voices is best viewed as something that can be coped with, using any one of a number of coping strategies. Group members are encouraged to try out different methods of coping with their voices as exercises set as homework. Finally, there is a focus on the improvement of self-esteem, and exercises to achieve such ends are performed.

The first three sessions revolve around engaging clients in a dialogue about their voices and encouraging the exchange of information. This part is particularly important as often the "voices" suggest to the patients that they should not attend in the future. The therapist must be aware of this possibility and suggest it to the group if it does not get discussed explicitly. A video of the BBC's Horizon programme "Hearing Voices" is used as a way of presenting other peoples descriptions of their voices so that it is possible to star a dialogue of how group members' "voices" are the same or different from the ones described in the video. The therapist should aid the group to discuss different models of "voices". The vulnerability-stress model is the one most easy for group members to

accept and the therapist should make sure that each member contributes to this sort of formolation i.e. by indicating instances of different types of stressor being associated with the exacerbation of the voices. Medication is always described by the therapist as providing a protective layer to a vulnerable (or sensitive person) in the context of reframing the group members' contributions.

The therapist must keep an open-minded approach and try not to appear to be supporting one type of model rather than another. Means of coping and their effectiveness are also discussed here. The therapist should take a more active role at this point in drawing together the different methods by categorising them and also suggesting new type.

Some work on coping is carried out in session 4 and homework was set so the beginning of the second phase of treatment this is reviewed and evaluated. Unsuccessful attempts are discussed and evaluated but the successful coping methods should be stressed. Emphasis here is on the ability to control the experience and the effect of this mastery on mood. Sessions 4 and 5 concentrate mostly on reinforcing coping attempts and discussing self-esteem and stigma. The final session reminds group members what they have discussed during the sessions and draws up a model of the psychotic experience as one which can be interpreted within the stress vulnerability context.

Confidentiality

To help promote trust between the therapist and group member's issues of confidentiality should be discussed at an early stage. The therapist should emphasise that he or she will listen to what the group members

say, and will encourage people to speak freely in the group. One of the rules of the group should be that no group members should discuss the contributions of other group members outside the group. The therapist should maintain that they also would not discuss anything group members say outside of the group, except in certain circumstances. Exceptional circumstances include the safety or distress of any group member.

In addition the therapist will inform the group member's treatment team of general progress of the therapy.

Equipment

Throughout the group therapy the therapist should take notes of the session on a **flip chart**. This enables the patients to be focus on the topic as well as acting as a reminder to the group of previous discussions. At the final session the vulnerability stress model is produced by the group members with guided questioning by the therapist.

The self esteem group and the coping strategy group will require some **small file cards** so that information about homework and the self esteem game can be played.

Group 1

- Introduce selves.
- Show first half of video (Horizon – 'Hearing Voices'). At the end ask the group to say what is the same or different about their voices.

Hearing Voices video is unavailable but you could use another DVD on voices.

Issues dealt with:

- Sharing of information about voices:
  - When did you begin to hear voices?
  - How often do you hear your voices?
  - How long do they usually last?
  - What kind of things do they say?
  - Are the voices loud or soft?
  - When do they usually happen – when alone? At night? When not busy?
  - How do they make you feel?
  - Do you know anybody else who has the same experiences?

* EMPHASISE THE SIMILARITIES BETWEEN GROUP MEMBERS' EXPERIENCES

- Introduce 'Normalising Rational'.
  - Leaders relate any 'odd' experiences they may have had.
  - Note wide experience of voice hearers in video.
- Introduce idea of 'Continuum of Experience'.

- Variety of odd or ‘abnormal’ experience i.e. mysticism, creative inspiration, voice the Gods (as in ancient mythology,) etc.

Therapist/s should maintain that the experience of voices is valid and real to the person themselves. Members should realise that although their experience of hearing voices is unique and personal to themselves, they are not the only voice hearers. Some voice hearers are present in society and are not in contact with psychiatric services. Therapists should suggest that for these people it may be that they differ in a number of different ways to people in the group. They may experience less distress or they might feel that the voices are less powerful that the ones experienced by the members of the group.

Group 2

- Show second half of video.

  Issues dealt with:

  . Models of psychosis in the video:

  - Medical model: - chemical imbalance in the brain, need medication to put it right, though it doesn't always work.
  - Psychological model: - 'it's all in my head, it isn't real'.
  - Both models combined: - use of medication to reduce vulnerability so that you can talk about the voices.

*** ASK GROUP MEMBERS TO COMMENT ON THE ISSUES COVERED IN THE VIDEO.**

- Medication:
  - Is it helpful?
  - If so, how is it helpful?
  - Does it get rid of the voices?
  - Does it make them more bearable?

. Other treatments for voices:
  - Does it help to talk about the voices?
  - Does it help knowing that others share the same experiences?

. Epidemiology of voice:
  - Many people hear voices.

- Some people come into contact with psychiatric services.
- Others do not receive any kind of help.

G**roup 3**

Issues dealt with:

- Models of hallucinations:
  - Where do the voices sound like they are coming from: -inside head? Outside head? Inside and outside?
  - If they sound like they're coming from outside the head, why can't anybody else hear them?
  - What do you think the voices are?
  - What do you think causes the voices? The brain? Spirits? The devil? Other people's thoughts? God? Etc.

EMPHASISE THIS POINT AND ASK ABOUT BEHAVIOURAL TESTS OF ANY HYPOTHESES.

Themes of Explanation

- Are the voices malevolent or benevolent?
- Grandiose, persecutory, punishment for past deeds, other peoples voices etc.
- How powerful are the voices?
- How should one treat the voices?
- What might happen if you ignore or disobey them?

Homework – Ask people to carry out a behavioural test of one of their themes.

G**roup 4**

Review the previous session on powerfulness. What did the group members try to do? How did it work? Are there any conclusions to be drawn from these experiences? For instance if a group member was able to resist a voice even if it was only a limited amount of time does that help other voice hearers to reassess the powerfulness of their own voices.

When are voices at their most powerful? Are there any similar circumstances in which voices are powerful amongst the group members? Some circumstances may be: stressful life events, periods of depression etc.

Methods of coping

Therapists should acknowledge that they realise many group members have been using coping strategies and have been coping with their voices on their own for a long time. Their resourcefulness and capabilities should also be acknowledged.

- What do you do to cope with the voices?
- How does this work?
- Have you tried any of the following strategies?:-
  - distraction – listening to music, watching television, talking to somebody
  - increased or decreased stimulation
  - ignoring the commands of the voices
  - telling the voices to go away

- postponing the voices until a later time in the day
- humming or singing to yourself
- focussing on the physical characteristics voices – volume, tone, male/female, etc.
- thinking about something nice and positive about yourself while you try to ignore the voice.

Acknowledge that coping strategies can require much effort and that different coping strategies are appropriate for different occasions. sometimes they will work and sometimes they don't.

What are the consistent strategies which work and in what situations do they work? Summarise findings on the flip chart. The strategies which work tend to be those which require some auditory processing and active involvement. Talking to someone is usually more effective than listening to music. Ask the group members to rate each of the strategies and see if there is any consistency...

- Homework:
  - each patient to try a new strategy for dealing with the voices

WRITE EACH OF THE SELECTED COPING STRATEGIES DOWN ON A FILE CARD FOR THE GROUP MEMBER TO TAKE HOME.

Group 5

Issues dealt with:

- Feed back the success of new strategies:
  - have new strategies been applied since the last meeting?
  - if so, what did you do and was it helpful?
  - do the strategies need modifying?
  - do different members need to use different methods of coping?

- Discussion of stigma and labelling
  - do you think that your symptoms are due to mental illness?
  - diagnosis: does it help to know that the 'voices' are due to an illness?
  - does the fact that you have 'different' experiences make you any worse than others?

- The role of medication:
  - is it helpful?
  - how is it helpful?
  - Only if the issue arises spontaneously but can suggest the way in which medicine can affect the brain neurochemistry. Liken it to other effects e.g. pain relief. If necessary agree to get more information such as that provided by the drug information service at the Maudsley.

- Recreational drugs, including alcohol:
  - do these make the voices worse or better?

- Homework:
- each patient to try another new strategy for dealing with the voices and to think of other strategies that may be helpful.

AGAIN WRITE DOWN THE STRATEGIES ON FILE CARDS FOR THE PERSON TO TAKE HOME WITH THEM AS A REMINDER.

Group 6

Issues dealt with:

- Feed back the success of new strategies:
  - ask patients to describe the coping strategies that they tried.
  - which ones did you find to be the most helpful?
  - are there any other coping strategies that you can think of?
  - encourage the experience of self efficacy.

- Self-esteem:
  - does your mood affect the experience of voices e.g. frequency severity?
  - do the voices affect mood i.e. circular maintaining model?
  - what do you think that other people think about you?
  - play the ***self-esteem game*** but only if members are willing to comply with i.e. it will not produce more paranoid ideation. This is based on an educational tool devised for improving self esteem and group cohesion in adolescents. Each group member writes his or her name down on a file card and passes it to the person on their right. This person writes down one positive thing about the person whose name is on the card and then passes it to their right and so on.

- When the card returns to the person whose name is at the top the ‘game’ stops. Positive comments can include “She’s jolly”, “She is easy to talk to”, “He always seems cheerful” etc. After the game ask how group members now feel. Usually the game produces increased feelings of well being.
- discuss how group members can use the cards or think positive things about themselves, especially when they hear the voices. Group members are encouraged to use the cards to help to improve their mood or to remind themselves about some of their “good points”.

. Homework:

- try to modify coping strategies using another strategy which has not been tried yet and encourage “positive thinking” with the use of the file card from the self esteem game.
- **NOTE** that a good strategy is humming which seems to work for everyone and requires little “effort” if group members have difficulty in using any strategy.

Group 7

In this group the model of voices is presented and it is very important for group members to "own" the model. For this reason the therapist/s should try to use the words which are suggested by the group in this session rather than the words usually used in describing these models in psychological or psychiatric texts.

- Feed back the success of new strategies:
  - ask patients to describe the coping strategies that they tried.
  - which ones did you find to be the most helpful?

- Discuss the vulnerability-stress model and write it onto the flip chart using the worlds that group members use. A basic model is presented in the appendix for the therapist to use as a template. Identify with group members the different possible ways of helping to reduce these distressing experiences e.g. medication for biological vulnerability (or psychological sensitivity), improving coping strategies, improving mood, decreasing stress in your lift etc. When the model has been produced group members often want to write this onto a price of paper to keep so ensure that there is enough writing tools available.

- Discussion of how members experienced the group:
  - what do you think you have learned?
  - how many different methods of coping do you now know of? (Perhaps get patients to write down two

different coping strategies on index cards which they found the most helpful so that they can remember them more easily when they are experiencing their voices.)

- how do you want to deal with the voices in the future?

Self esteem game – Everyone in the group is issues with a card – including the therapists. Each person puts their name on the card they have been issued. Then they give the card to the person on their left. That person then writes down something about the person named on the card. This should be a positive comment (e.g. nice smile, always friendly etc) Do not give too many examples at the beginning of the game – allow some initiative. After writing one thing down, the card is then passed to the next person on the left and they also add their comment on the person named on the card. The game continues until the card is returned to the person whose name is at the top. The facilitator then asks what the comments make people feel. The change in mood is emphasised as this is part of talking about how thoughts can influence mood.

All people keep their cards and it is suggested that they might want to look at them when they feel in a low mood.