



# Does mindfulness help people adapt to the experience of hearing voices?

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## ABSTRACT

Mindfulness-based interventions show promise in the treatment of psychotic symptoms. From a theoretical perspective, there may be several benefits of mindfulness for individuals who experience hearing voices. Related cross-sectional findings suggest mindfulness may protect against distress, disruption, negative beliefs, dysfunctional relational style and responding, and mood symptoms for individuals who hear voices. To extend on previous findings, this study aimed to identify whether mindful relating to voices predicted voice-related negative impacts (distress, disruption and resistance), when the influence of voice-topography and mood symptoms were controlled for. Overall, 62 participants with a psychotic disorder who had experienced hearing voices in the previous week were given the Southampton Mindfulness of Voices Questionnaire, Psychotic Symptom Rating Scales, Beliefs About Voices Questionnaire, Beck Depression Inventory-II, and Beck Anxiety Inventory. As predicted, greater mindfulness of voices predicted less voice-related distress and lower resistance to voices. Regression analyses revealed that when associated voice topography and mood symptoms were controlled for, mindful relating to voices explained a significant proportion of variance in voice-related distress and resistance. Conversely, mindfulness of voices did not significantly predict voice-related disruption. In the context of existing literature, these findings suggest further mindfulness-based protocols for persistent voices should be developed and trialed.

## 1. Introduction

The occurrence of persisting positive symptoms, such as auditory verbal hallucinations (or ‘voices’) and delusions is most prominent in schizophrenia spectrum disorders, with up to 80% reporting the experience of such symptoms (Andreasen and Flaum, 1991). However, prevalence of positive psychotic symptoms, such as voices, have also been reported in affective disorders such as bipolar disorder and major depressive disorder, albeit at lower rates (Toh et al., 2015). Furthermore, many individuals continue to experience these positive psychotic symptoms, despite the use of antipsychotic medication (Elkis, 2007; Hegarty et al., 1994). These persisting positive symptoms of psychosis have been found to be a strong predictor of rehospitalisation rates, distress, depression and anxiety (Smith et al., 2006; Sota, 2000). These findings highlight the importance for psychological therapies to target these refractory symptoms (Burns et al., 2014).

The application of mindfulness-based therapies to help people with persisting psychotic symptoms, has been one of the most prominent recent therapeutic developments in this field (Thomas et al., 2014a).

Mindfulness involves paying attention to present-moment experiences, such as internal psychotic experiences, purposely and non-judgementally (Kabat-Zinn, 1994). It has been suggested the cultivation of mindful awareness helps individuals develop an alternate relationship with psychotic symptoms and lessens the likelihood of becoming pre-occupied by ineffective habitual reactions, such as struggle or engagement (Abba et al., 2008).

A recent meta-analysis by Louise and colleagues (2017) found moderate treatment effects of group format mindfulness-based interventions on psychotic symptoms (Hedge's  $g = 0.46$ ), compared with control post-treatment. However, despite the existence of several randomised control trials (RCTs) of mindfulness interventions for psychosis in extant literature (Chadwick et al., 2016; Chien and Lee, 2013; Chien and Thompson, 2014; Langer et al., 2012; López-Navarro et al., 2015), only one of these trials considered outcomes on persistent voices (Chadwick et al., 2016). Chadwick et al. (2016) identified significant between group post-intervention effects on negative voice impacts, such as voice-related distress and perceived controllability, following a course of Person-Based Cognitive Therapy (PBCT), incorporating

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cognitive therapy and mindfulness.

A recent review by [Strauss et al. \(2015\)](#) proposed several theoretical reasons why mindfulness might be of particular benefit for individuals experiencing persistent voices. Specifically, i) mindful observation may protect against preoccupation with verbal engagement with voices, ii) acceptance presents an alternative to experiential avoidance or suppression that may maintain voices and related distress, iii) a decentered awareness may reduce the impact of negative voice-content and self-beliefs on distress, and iv) targeting of control behaviours, such as rumination and worry, often experienced with voice hearing that may maintain this experience and/or associated distress.

If mindfulness is helpful as a therapeutic mechanism in adapting to persisting voices, it would be expected that individual differences in trait mindfulness would predict lower negative voice impacts, such as distress, disruption, and negative responses to voices. These dimensions are a common target of psychological therapies, and as such, numerous studies have confirmed that beliefs targeted in cognitive therapy (i.e. that voices are malevolent and powerful) predict distress and responding to voices with attempts to resist them ([Hayward et al., 2011](#)). However, few studies to date have looked at how individual differences in mindfulness may predict these voice impacts. [Chadwick et al. \(2007\)](#) found that mindful relating to voices (Southampton Mindfulness of Voices Questionnaire; SMVQ) was associated with lower negative affect, voice-related distress and resistance to voices. [Morris et al. \(2014\)](#) found non-judgemental acceptance (Kentucky Inventory of Mindfulness Skills) was associated with lower resistance of voices and improved mood (depression and anxiety). Conversely, no significant associations were found between non-judgemental acceptance and voice-related distress and disruption. Similarly, regression analysis identified non-judgemental acceptance to significantly predict resistance to voices, but not mood symptoms or voice-related distress or disruption. However, these findings are restricted by the fact that [Morris et al. \(2014\)](#) did not explore the impact of other trait mindfulness characteristics, such as mindful observation and awareness, due to methodological limitations.

Additionally, [Úbeda-Gómez et al. \(2015\)](#) found that mindfulness (Mindful Attention Awareness Scale; MAAS) was negatively correlated with voice-related distress and dissociative symptoms. More recently, [Perona-Garcelán et al. \(2016\)](#) found that mindfulness (MAAS) predicted lower mood symptoms and mediated an observed association between dysfunctional relational style and mood.

These findings suggest there is preliminary evidence that trait mindfulness may be associated with better adaptation to the experience of hearing voices. However, findings for voice-related impacts are somewhat inconsistent in relation to distress ([Chadwick et al., 2007](#); [Morris et al., 2014](#)). Additionally, most of these studies looked at mindfulness as a general trait measure, rather than specifically at an individual's ability to relate mindfully to their voices ([Morris et al., 2014](#); [Perona-Garcelán et al., 2016](#); [Úbeda-Gómez et al., 2015](#)). [Chadwick et al. \(2007\)](#) study that did look at mindfulness of voices was limited by the inclusion of an unvalidated rating of voice-related distress, and use of the *resistance* scale of the Beliefs About Voices Questionnaire-Revised (BAVQ-R). This scale indexes a combination of both behavioural and emotional responses to voices, resulting in the inclusion of items of voice-related emotional distress.

Furthermore, cross-sectional studies to date have not controlled for the effects of voice topography and overall distress (depression and anxiety) on voice-related negative impacts. In clinical populations hearing voices is often, but not always, associated with experienced distress ([McCarthy-Jones et al., 2012](#)). Given measures of voice-related distress may be influenced by overall mood symptoms, and by voice frequency, duration and intensity, these variables are important to consider as confounds in examining the relationship between processes such as mindfulness and the impact of voices ([McCarthy-Jones et al., 2012](#); [Soppitt and Birchwood, 1997](#)).

## 1.1. Research aims and hypotheses

The present study explored the relationships between mindful relating to voices, voice-related negative impacts (distress, disruption and resistant responding), voice topography and mood (depression and anxiety). This study aimed to identify whether mindful relating to voices predicted voice-related negative impacts, when the influence of voice topography and mood symptoms were controlled for. It was predicted that when confounding voice topography and mood symptoms were controlled for, a significant amount of variance in voice-related distress, disruption and resistance would be explained by trait-based mindful responding to voices.

## 2. Method

### 2.1. Participants

In total, 62 participants were recruited from inpatient and outpatient mental health services, a specialist Voices Clinic in Melbourne, Australia, and online and print advertisements. Inclusion criteria were: 1) a previous diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depressive disorder, 2) over 18 years of age, and 3) experienced hearing voices within the last week, as part of an ongoing mental health disorder (as obtained via the PSYRATS interview – see below). Exclusion criteria were: 1) history of neurological disorder, 2) electroconvulsive therapy in the past six months, 3) a current substance dependence disorder, or 4) a Wechsler Test of Adult Reading (WTAR; [Wechsler, 2001](#)) estimated IQ < 70, to ensure informed consent and meaningful information in the context of the clinical interview could be provided. Participants provided written informed consent in accordance with approved ethical requirements and the Declaration of Helsinki ([World Medical Association, 2008](#)) and were financially reimbursed for their time and travel costs.

### 2.2. Design and procedure

Ethical approval to collect the data was sought by five independent Human Research Ethics Committees (HREC): The Alfred Hospital, The Melbourne Clinic, the Epworth Hospital, St Vincent's Hospital and Swinburne University of Technology. All procedures outlined were conducted in line with this ethical clearance. This study used a cross-sectional design, with all demographic information and clinical measures completed at one time point. Following a basic telephone screen for eligibility, participants completed a demographic questionnaire and self-report measures. Subsequently, one of two trained researchers administered the clinician-rated measures. These measures were administered over one or two sessions within a one week period.

### 2.3. Measures

#### 2.3.1. Psychotic symptoms rating scales – auditory hallucinations (PSYRATS; [Haddock et al., 1999](#))

A measure of the specific characteristics of auditory hallucinations, consisting of 11 items assessing: frequency, duration, location, loudness, beliefs about origin, amount and degree of negative content, amount and intensity of distress, disruption and control. Items are rated on 5-point (0 to 4) anchored interviewer-rated scales, with higher scores indicating greater severity. The scale was administered to patients to ensure inclusion criteria were met regarding frequency of experienced voices (i.e. 'voices occur for at least once a week'). Also, to obtain specific information about voice-related distress, disruption and voice topography (frequency, duration, loudness).

#### 2.3.2. Beliefs about voices questionnaire – revised (BAVQ-R; [Chadwick et al., 2000](#))

A 35-item measure of people's beliefs about auditory verbal

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