Behavioural and Cognitive Psychotherapy, 2005, 33, 351–359
Printed in the United Kingdom doi:10.1017/S1352465805002158

Mindfulness Groups for People with Psychosis

Paul Chadwick

University of Southampton & Royal South Hants Hospital, Southampton, UK

Katherine Newman Taylor and Nicola Abba

Royal South Hants Hospital, Southampton, UK

Abstract. The study's objective was to assess the impact on clinical functioning of group based mindfulness training alongside standard psychiatric care for people with current, subjectively distressing psychosis. Data are presented from the first 10 people to complete one of four Mindfulness Groups, each lasting six sessions. People were taught mindfulness of the breath, and encouraged to let unpleasant experiences come into awareness, to observe and note them, and let them go without judgment, clinging or struggle. There was a significant pre-post drop in scores on the CORE ($z = -2.655$, $p = .008$). Secondary data indicated improvement in mindfulness skills, and the subjective importance of mindfulness to the group process ($N = 11$). The results are encouraging and warrant further controlled outcome and process research.

Keywords: Mindfulness, psychosis, voices, images, paranoia.

Introduction

Mindfulness based interventions

Mindfulness has been defined as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994, p. 4). Mindfulness and cognitive therapy share a common premise – that distress and suffering result from the mind rather than directly from sensations or events. They also share an intention to alleviate that distress. In a meta-analytical review of the evidence for mindfulness based interventions, Baer (2003) states "the empirical literature on the effects of mindfulness training contains many methodological weaknesses, but it suggests that mindfulness interventions may lead to reductions in a variety of problematic conditions, including pain, stress, anxiety, depressive relapse, and disordered eating."

The two main interventions that examine mindfulness as an independent intervention are Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 1990) and Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams and Teasdale, 2002). MBSR is a structured 8–10-week program for groups of people with diverse conditions, including chronic pain,

Reprint requests to Paul Chadwick, Department of Clinical Psychology, Department of Psychiatry, Royal South Hants Hospital, Southampton SO14 OYG, UK. E-mail: paul.chadwick@wht.nhs.uk

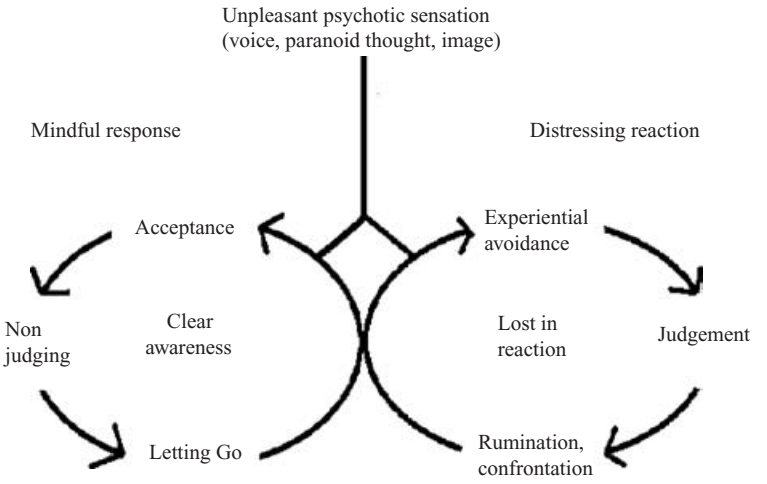

Figure 1. Rationale for applying mindfulness to distressing psychotic sensations

AIDS, heart disease, anxiety and depression. MBCT grew out of MBSR and is an 8-week program designed to prevent relapse in those suffering recurrent episodes of depression. The aim is to establish a "decentred relationship to depression-related thoughts and feelings . . . (that) helps prevent the escalation of negative thinking patterns at times of potential relapse" (Segal, Teasdale, Williams and Gemar, 2002). In both MBSR and MBCT, mindfulness is taught through a range of practical exercises including sitting meditation and yoga, and the training requires daily practice. The research to date suggests that these approaches are likely to be effective in managing stress, pain and physical health problems (MBSR; Kabat-Zinn, 1990) and reduce recurrence of depression (MBCT; Teasdale et al., 2002).

Mindfulness, distress and psychosis

Segal, Williams et al. (2002, pp. 64–65) stress the importance of having a clear formulation when using mindfulness training with a specific disorder. Chadwick, Birchwood and Trower (1996) argue that cognitive therapy for psychosis should not be aimed at trying to control psychotic symptoms such as voices, images and paranoid intrusions, but at alleviating the distress associated with them (the C in their ABC model). This is consistent with the rationale for mindfulness. Mindfulness traditions are explicit about the type of reactive relationship to experience/sensations that causes distress, and how to relate mindfully to sensations so as to alleviate distress. Applying this to psychosis, we propose a specific model of how mindfulness might alleviate distress associated with psychosis (see Figure 1).

In the face of an unpleasant psychotic sensation (voice, paranoid thought, image), distress results from an absence of clear awareness of what is being experienced, and being lost in experiential avoidance, negative judgment of the sensation or the self or both, and rumination/confrontation. Experiential avoidance is defined as occurring when a person is unwilling to remain in contact with sensations (e.g. thoughts) and takes steps to alter the

form or frequency of those events and the contexts that occasion them (Hayes, 1994). In psychosis judgement of psychotic sensations is almost always of an experienced "other" – that is, a voice or a persecutor. We link rumination and confrontation because both express resistance (Chadwick and Birchwood, 1994) of the "other". Underpinning these reactions is an assumption that the "self" (which is reified) is defined by these experiences and how one reacts to them. There is empirical evidence that people with psychosis react to voices (Birchwood and Chadwick, 1997) and paranoia (Freeman, Garety and Kuipers, 2001) in these ways.

In direct contrast, a mindful response involves clear awareness and acceptance of psychotic sensations as transient experiences that are fundamentally "not me" (i.e. do not define the self), and not necessarily accurate reflections of reality. Acceptance is defined as being open and receptive to whatever we are hearing, thinking or seeing because it is there (Kabat-Zinn, 1990). A mindful response involves observing unpleasant psychotic sensations pass, and allowing this movement in and out of awareness without getting caught in rumination or confrontation. Whilst psychotic sensations experienced mindfully likely remain unpleasant, or painful, the distress (or suffering) that comes from reacting against them is absent.

In Baer's review there is no study applying mindfulness as an independent component to psychosis (although Acceptance and Commitment Therapy has shown promising results with people with psychosis; Bach and Hayes, 2002). A scarce literature exists on meditation and psychosis, and it contains cautions against teaching meditation to people vulnerable to (Yorston, 2001) or currently experiencing active symptoms of psychosis (Deatherage and Lethbridge, 1975). This literature refers chiefly to isolated single cases, lacks experimental rigour, and includes a wide range of meditation experiences (i.e. forms of meditation and type of exposure). Nevertheless, with these cautions in mind, in the present study we established a clear, narrow aim of seeking to help people establish a mindful relationship with unpleasant voices, images and paranoid thoughts, rather than to seek to promote mindfulness in everyday life (whilst eating, walking, moving). In addition, we made several adaptations to the MBSR and MBCT approaches in order to minimize the likelihood of possible harmful effects among people with psychosis. First, we taught only mindfulness of the breath, and did so in two shorter (10 minute) sittings each session. Like MBSR and MBCT, all practice began with mindfulness of the body. This involved spending the first minute inviting people to bring their awareness into their bodies, and carrying out a brief body scan (as is done in 3-minute mindfulness practice in MBCT). This was hypothesized to help ground clients. Also, following MBSR and MBCT, mindfulness was taught as "choiceless attention" rather than concentration meditation, as states of deep absorption can be linked to onset of hallucinations. Second, all mindfulness practice was guided, with instructions and gentle comments or reminders being offered every couple of minutes. This was to prevent extended periods of silence, when people might become lost in reactions to psychosis. Third, homework was encouraged but not required, and further 10-minute sittings were suggested (audiotapes were provided to guide these). Fourth, we shortened the structure to six sessions of 90 minutes, which included a 15-minute break for coffee, when many people left the room for cigarettes. Fifth, whilst the main purpose of the groups was to teach mindfulness, it felt important to recognize that for people presently experiencing severe distressing psychosis, an emphasis on therapeutic process and relationship, as well as structure, is essential (Yalom, 1995). All clients experienced high levels of anxiety, paranoia and voices leading up to and during groups; managing this therapeutically was judged essential if people were to practise and reflect on mindfulness. Sixth, with this last point in mind, groups began with up to six participants only.

We report outcome data from the first 11 people with subjectively distressing psychosis to complete one of four mindfulness groups (though one man chose to complete only the measure of therapeutic process). All participants received medication and standard psychiatric care throughout, so the research examines the effectiveness of mindfulness plus treatment as usual.

Method

Participants

Participants were 15 people with unremitting, distressing psychotic experiences of at least 2-years duration referred to a psychology service for people with distressing psychosis. People are referred to this service by professionals working anywhere in the adult mental health service. They enlisted into one of four mindfulness groups, offered as one of the standard available options. One man decided not to attend, at the instruction of his voices, before his group started. Three people dropped out after one session, from separate groups. Participants were free to attend more than one group (six did so) but we present data from each participant's first group only. Group 1 comprised 4 people (one drop out); Group 2 comprised 3 new people and 2 "repeaters" (one drop-out); Group 3 comprised 3 new people, and 2 "repeaters"; and Group 4 comprised 3 new people (one drop-out) and two "repeaters".

Hereafter we discuss the seven men and four women who provided data (one man attended five of six sessions, but chose to complete no measures other than rating of therapeutic factors). Participants' mean age was 33.1 (*SD* 8.9). All had paranoid beliefs, six heard voices and five experienced other hallucinations (four visual, one tactile). For all 11 there were associated negative self-schemata, and symptoms of anxiety and depression. At the time of the groups, nine met diagnostic criteria for paranoid schizophrenia, and two for schizoaffective disorder (American Psychiatric Association, 1994). Ten people were unemployed and one was a full-time student. Five people lived alone in flats; three had lived for over 12 months in a 24-hour staffed hostel for homeless people who were vulnerable and difficult to settle; two lived with families; and one had been an in-patient for 18 months. The mean number of years of contact with psychiatric services was 6.9 (range 2–15).

Measures

Clinical Outcomes in Routine Evaluation (CORE). was used as the primary outcome measure. The 34 items assess subjective well-being, problems/symptoms, life functioning and risk. CORE was developed for use in routine clinical practice, where it has been found to be both reliable and valid (CORE handbook, 1988).

Mindfulness Questionnaire[1]. The 16 items measure the degree to which people respond mindfully to distressing experience. Parallel versions exist for voices and distressing thoughts/images. Items assess "Letting Come", "Mindful Observation", "Non-judgment", "Letting Go", and are scored 0–6. Initial data from a community sample of 134 indicate

[1] Mindfulness Questionnaire: available from the first author.

https://doi.org/10.1017/S1352465805002158 Published online by Cambridge University Press

that the measure is reliable (Cronbach's alpha = 0.9) and does indeed measure mindfulness (Hember, 2003).

Therapeutic factors. At post group independent assessments, individuals ranked from most to least important two parallel lists of statements relating to the same eight therapeutic factors: Altruism, Group Cohesiveness, Universality, Interpersonal Learning, Mindfulness, Catharsis, Self-understanding and Instillation of Hope (Yalom, 1995). The original factor, Guidance, was replaced with statements about mindfulness as this is what participants were guided in.

Referral and assessment process for mindfulness groups

All people initially referred to the psychosis service were assessed and a case formulation of their distress was developed and shared. All formulations of those offered the mindfulness groups indicated that clients' relationship with psychosis was characterized by avoidance, judgement and struggle. An assessment for group participation then occurred. This covered: (1) discussion of the group rationale and aims, including clarity that mindfulness is not intended to "get rid" of voices etc, but to develop a less distressing relationship with them; (2) 3–5 minutes guided mindfulness practice; (3) information that this was a new approach for psychosis and an invitation to work with therapists to help gauge its value; (4) clarity that the group required neither exploration of past history nor disclosure of traumatic experience; (5) emphasis that participation was voluntary; (6) Socratic exploration of concerns and hopes regarding attendance. After assessment twelve people chose to join mindfulness groups. Three felt too anxious to join a group, and initially received individual CBT (two of whom therapists judged to have responded, one not); after the conclusion of CBT they were reviewed and chose to join a mindfulness group.

Mindfulness treatment package

The first author (8 years mindfulness practice) and second (4 years mindfulness practice) ran an initial pilot group ($N = 5$) to establish the protocol, and subsequently led the first two groups reported here. PC then ran groups three and four with colleagues without mindfulness experience. All groups lasted 6 weeks. Sessions lasted 90 minutes, with a 15-minute break. Four people attended all sessions, five missed one session, and two missed two sessions.

Session one began with exploration of how people felt coming to the group, and the establishment of ground rules (confidentiality, respect for others' experience and opinions, and freedom to choose what to disclose). The rationale for applying mindfulness was then introduced through Socratic discussion of how people currently reacted to distressing experiences and how effective these strategies were. Mindfulness was offered as an alternative response to complement existing coping strategies. Subsequent sessions began with 5–10 minutes general discussion of the past week, including distressing experiences. Discussion then narrowed down to whether people had either considered or used mindfulness (practice was not a requirement); questions, difficulties and any necessary refinements were dealt with. The first of two guided 10-minute mindfulness practices followed. The second practice occurred straight after the break. Participants were taught mindfulness of the breath, following a brief (one minute) focus on the body. Audiotapes of guided mindfulness practice were

supplied free to support practice. Therapists led each practice, offering gentle and brief prompts every 2 minutes or so throughout, to help people refocus awareness and also avoid lengthy silence. From session three onwards an aspect of mindfulness (Letting Go, Acceptance, Non-judging) was emphasized through a mix of teaching, Guided Discovery and linked prompts during the second practice. Therapists regularly asked about group members' understanding of mindfulness, as this highlighted both growing awareness and any remaining gaps in understanding.

Results

Clinical functioning

CORE was the primary outcome measure. Descriptive statistics from the 10 participants' scores are as follows. On average, Total CORE scores were higher before mindfulness training (time one: range = 1.2–3.4, mean = 1.947, $SD = 0.715$; time two: range = 0.3–3.2, mean = 1.522, $SD = 0.889$). Wilcoxon pairwise analysis revealed a significant reduction in total CORE score over the duration of the group ($z = -2.655$, $p = .008$). The direction of change in CORE scores was positive for 9 of the 10 people to complete this measure. The repeated measures design and small numbers render calculation of effect sizes premature.

Responding mindfully to voices, thoughts and images

Mindfulness Questionnaire data assessed the process question: did people become more able to respond mindfully to distressing thoughts/images, voices or both? As scaling of the questionnaire changed slightly after the first group, we report only percentage changes. For distressing thoughts/images, all participants scored higher post group: percentage increase in scores ranged from 2.7 to 111, with a mean increase of 36.6%. For voices, one person's score was lower by 10% at time two than time one. All other scores were higher at time two, and there was an overall increase in scores of 42%. At time one, mindfulness scores for voices were approximately 20% lower than for thoughts/images (i.e. people were less mindful of voices than their distressing thoughts/images).

Verbatim comments from the post-group assessments with an independent clinician indicated no adverse effects for participants of either being in the group or learning mindfulness, and illuminated the process of responding mindfully to psychotic experience. One participant stated "When you get the voices, let them do what the voice is saying, let the voices happen and you'll find out that they meant nothing anyway. How can I put it? If you've got voices controlling you, try and just let it and then you'll find out that it didn't control you after all, it's just a voice." Another person said, "I suppose it just centres you. You don't have to worry about what's right and what's wrong in your head, you know it's that not judging what goes through your head, it's just accepting it as it is, not worried about vindictive voices, or whatever, it's just accepting that's the way it is. No right, no wrong."

A man with distressing paranoia said "It focused me on something else apart from my thoughts. It's a way of trying to not get the thoughts to go away, but to stop worrying about them and the anxiety about them. Rather than going round and round in my head, 'This is going on, why is this happening?', sort of like when I do that, it just stops going round and round in my head." Regarding their distressing images, another person said "There's loads of

https://doi.org/10.1017/S1352465805002158 Published online by Cambridge University Press

different images and things in my head and that was okay, whereas before when I first started the mindfulness group and this kind of thing was happening I was fighting against it, thinking, 'No, this is wrong, this is wrong', fighting against these images. Like today it was just let them come."

The approach of accepting psychotic experience, rather than judging and striving to get rid of it, was described as "a completely new way of looking at it, you know of accepting it instead of fighting non-stop, worrying about it, thinking 'Oh my God, another relapse' – just accept it."

Therapeutic process

Data on subjective importance of therapeutic factors were as follows. For list A, the rank order from most (ranked 1) to least (8) important was: Mindfulness (Mean 2.3, *SD* 1.6), Universality (Mean 2.8, *SD* 1.7), Interpersonal learning (Mean 4.4, *SD* 2.2), Group cohesion (Mean 4.8, *SD* 1.9), Catharsis (mean 4.9, *SD* 2.3), Self-understanding (5.2, 2.6), Hope (5.4, 2.5) and Altruism (6.1, 1.5). For list B, rankings were: Mindfulness (2.7, 1.7), Universality (2.9, 2.2), Catharsis (3.4, 2.2), Self-understanding (4.2, 2.8), Interpersonal learning (5, 1.2), Hope (5.2, 1.6), Group cohesion (6, 2.3), Altruism (6.6, 2). Overall rankings of factors were: Mindfulness (1), Universality (2) Interpersonal Learning/Catharsis (tied 3), Self-understanding (5), Group cohesion (6), Hope (7) and Altruism (8).

Discussion

The aim of the present study was to help people with reactive, distressing relationships to psychotic sensations to establish a mindful relationship with these experiences, so as to reduce distress. CORE data showed that participation in a mindfulness group, alongside standard psychiatric care, was associated with an improvement in general clinical functioning in 10 people with severe and enduring psychosis. The CORE was chosen as the primary outcome measure because it is designed for use in clinical practice, and because most items assess emotional or behavioural experience – a more client-centred outcome than symptom intensity (Chadwick et al., 1996). Nevertheless, future outcome research might usefully include symptom based measures to assess for change in specific dimensions of psychotic experience. Future research might also test for generalization through a broader measure of mindfulness, such as the MAAS (Brown and Ryan, 2003), which assesses mindfulness in everyday situations (e.g. when eating) – although, this is perhaps less likely than in MBSR or MBCT, because in the present study the rationale for learning mindfulness, the choice of practice (i.e. breathing only) and the emphasis throughout groups lay in relationship to psychotic sensations.

The present study is especially encouraging given concerns in the literature about teaching meditation to people with psychosis. Comments at post-group independent assessment were equally encouraging. The fact that 6 of the 11 people chose to attend a second group again suggests that they did not find the experience harmful. Yet caution is still required; more rigorous experimental design and assessment are required in further research. Also, at least one therapist in each group was experienced in mindfulness, CT and group therapy, and the groups were facilitated in an open, accepting and collaborative CT style. Generalization to other therapists, therapeutic approaches, types of meditation and clients cannot be assumed.

https://doi.org/10.1017/S1352465805002158 Published online by Cambridge University Press

Limited experimental control precludes assuming that mindfulness practice was either a necessary or sufficient cause of clinical improvement. Yet rankings of therapeutic factors showed that mindfulness practice was *subjectively* more important than non-specific therapeutic factors, and Mindfulness Questionnaire data were suggestive of consistent improvement (although, again, it might be argued that these ratings reflected demand characteristics). Participants described in their own words to an independent clinician responding mindfully to unpleasant voices, paranoid thoughts and images, although effects might also reflect changes in their relationship with non-psychotic symptoms. When viewed within the wider context of growing support for the therapeutic effects of mindfulness training (Baer, 2003), it is reasonable to propose that mindfulness training contributed to clinical improvement in the present sample, and to recommend more rigorous empirical investigation.

Acknowledgements

Sincere thanks to all participants, Christina Morberg-Pain and Liz Jones.

References

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th edn., rev.) Washington, DC: APA.

Bach, P. and Hayes, S. C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomised controlled trial. *Journal of Consulting and Clinical Psychology, 70*, 1129–1139.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: a conceptual and empirical review. *Clinical Psychology: Science and Practice, 10*, 125–143.

Birchwood, M. J. and Chadwick, P. D. J. (1997). The omnipotence of voices: testing the validity of a cognitive model. *Psychological Medicine, 27*, 1345–1353.

Brown, K. W. and Ryan, R. M. (2003). The benefits of being present: mindfulness and its role in psychological wellbeing. *Journal of Personality and Social Psychology, 84*, 822–848.

Chadwick, P. D. J. and Birchwood, M. J. (1994). The omnipotence of voices: a cognitive approach to auditory hallucinations. *British Journal of Psychiatry, 164*, 190–201.

Chadwick, P. D. J., Birchwood, M. J. and Trower, P. (1996). *Cognitive Therapy for Delusions, Voices and Paranoia*. Chichester: Wiley.

CORE (1988). *Clinical Outcomes in Routine Evaluation (CORE) Handbook*. CORE system group.

Deatherage, G. and Lethbridge, U. (1975). The clinical use of "mindfulness" meditation techniques in short-term therapy. *Journal of Transpersonal Psychology, 7*, 133–143.

Freeman, D., Garety, P. and Kuipers, E. (2001) Persecutory delusions: developing the understanding of belief maintenance and emotional distress. *Psychological Medicine, 31*, 1293–1306.

Hayes, S. C. (1994). Content, context and the types of psychological acceptance. In S. C. Hayes, N. S. Jacobson, V. M. Follette and M. J. Dougher (Eds.), *Acceptance and Change: content and context in psychotherapy* (pp. 13–22). Reno, NV: Context Press.

Hember, M. (2003). *Establishing Reliability and Validity of the Mindfulness Questionnaire*. Unpublished MSc thesis, University of Southampton.

Kabat-Zinn, J. (1990). *Full Catastrophe Living: the program of the Stress Reduction Clinic at the University of Massachusetts Medical Centre*. New York: Dell.

Kabat-Zinn, J. (1994). *Wherever You Go, There You Are: mindfulness meditation in everyday life*. New York: Hyperion.

Segal, Z. V., Teasdale, J. D., Williams, J. M. and Gemar, M. C. (2002). The mindfulness-based cognitive therapy adherence scale: inter-rater reliability, adherence to protocol and treatment distinctiveness. *Clinical Psychology and Psychotherapy, 9*, 131–138.

Segal, Z. V., Williams, J. M. and Teasdale, J. D. (2002). *Mindfulness-Based Cognitive Therapy for Depression*. Guildford: Wiley.

Teasdale, J. D., Moore, R. G., Hayhurst, H., Pope, M., Williams, S. and Segal, Z. V. (2002). Metacognitive awareness and prevention of relapse in depression: empirical evidence. *Journal of Consulting and Clinical Psychology, 70*, 275–287.

Yalom, I. D. (1995). *The Theory and Practice of Group Psychotherapy* (4th ed.) New York: Basic Books.

Yorston, G. (2001). Mania precipitated by meditation: a case report and literature review. *Mental Health, Religion and Culture, 4*, 209–213.