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Psychosis: Can Mindfulness Help?

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Psychosis: Can Mindfulness Help?

Mindfulness originated out of Buddhism, but in recent years it has been utilized as a psychological intervention outside the context of Buddhism. Mindfulness is defined as “paying attention in a particular way: on purpose, in the present moment and non-judgmentally” (Kabat-Zinn, 1994, p. 4). Mindfulness is based on the assertion that distress occurs not as a direct consequence of experience, but instead is caused by an individual’s response to such experiences (Abba, Chadwick, & Stevenson, 2008). Therefore, mindfulness serves to alleviate distress by helping people learn to react to their experiences in a different way. That is, it helps people to experience thoughts and sensations as they are, without judgment.

The use of mindfulness as a clinical intervention has become relatively common in outpatient settings with clients who are not in an acute phase of illness, and whose problems are not severe. Baer (2003) conducted a meta-analysis in which she reviewed 21 studies that had used Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990) or Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale) to train individuals in mindfulness. The findings from Baer’s review support the use of mindfulness-based interventions for a variety of clinical presentations, including chronic pain, generalized anxiety, depression, and psoriasis.

Although mindfulness has become a frequently used approach in the treatment of less severe psychological problems, there continues to be debate about whether mindfulness-based interventions are useful in the management of serious psychiatric illnesses, especially those in the acute phase of illness (Segal, Williams, Teasdale, 2002). However, there is growing evidence that mindfulness-based treatment interventions can be effectively utilized in the management and treatment of more severe pathology. Specifically, it has been demonstrated to

be useful in the management of suicidality, borderline personality disorder, and psychosis (Didonna, 2009). The current paper provides an overview of the available literature regarding the use of mindfulness-based treatment interventions with individuals diagnosed with a psychotic disorder. The research review will include studies using both inpatient and outpatient samples.

Psychotic disorders, such as Schizophrenia, are most often chronic conditions that cause significant distress and functional impairment to those affected (Pratt & Mueser, 2002). Despite good treatment compliance, many individuals with these conditions will continue to experience residual psychotic symptoms as well as comorbid psychiatric conditions (Breier, Schreiber, Dyer, & Pickar, 1991). Such symptoms constitute a primary reason for re-hospitalization among previously hospitalized individuals with these conditions (Sota, 2000). Thus, the development of effective psychosocial treatment interventions for this population is vital.

A number of randomized clinical trials (RCT's) have demonstrated the efficacy of Cognitive-Behavioral Therapy (CBT) as an adjunct to psychopharmacological interventions in the treatment of psychotic disorders (Gaudiano, 2005; Rector, & Beck, 2001). However, the majority of these RCT's have used outpatient samples and there are very few that have investigated the efficacy of CBT in the treatment of inpatients with psychosis. The few RTC's that have used an inpatient sample have continued treatment on an outpatient basis following hospital discharge (Startup, Jackson, & Bendix, 2004). Therefore, the findings from these studies may not be generalizable as research suggests that up to 75% of psychiatric patients do not follow through with outpatient treatment after being discharged from the hospital (Nelson, Maruish, & Axler, 2000). Based upon this data, it seems imperative that psychologists develop more effective psychosocial interventions to treat individuals with psychotic disorders during their hospitalization.

Recently, the use of mindfulness-based treatment approaches for the management of psychotic symptoms has received growing attention. According to Jacobson, Morris, and Johns (2010), the use of mindfulness with this population is based on the observation that individuals who experience distress as a result of psychotic symptoms, such as hallucinations or delusion, frequently engage in avoidance strategies (substance abuse, suppression, distraction), or on the other extreme, may become engrossed in their symptoms (rumination, confrontation). Mindfulness can provide these individuals with an alternative way of relating to their symptoms, potentially resulting in the reduction of subjective distress. Thus, the primary goal behind the use of mindfulness-based interventions with individuals experiencing psychosis is to help these them learn “to allow unpleasant psychotic experiences to come into awareness; letting go of struggle, judging, and rumination; and accepting both psychotic experience and oneself” (Chadwick, Hughes, Russell, Russell, and Dagnan, 2009, p. 410).

Taylor, Harper, and Chadwick (2009) investigated whether mindfulness effects change in affect and cognition associated with the experience of auditory hallucinations. The researchers present case studies of two males diagnosed with Paranoid Schizophrenia who, despite compliance with pharmacotherapy, were experiencing auditory hallucinations at the time of the study. Both participants received 12, one-hour, weekly sessions, and they were encouraged to practice between sessions using guided CD’s that had been provided to them. Each session included two brief meditative practices which included breathing meditations and an initial grounding the body exercise (body scan). Each practice was followed by Socratic questioning and a discussion about the participant’s use of mindfulness both in session and independently. Results from pre and post testing showed the impact of mindfulness on two dimensions: distress and belief conviction. Although there was no decrease in the frequency of auditory

hallucinations, the participants reported that these experiences were not as distressing, and they reported a decrease in the level of believability of their symptoms. Considering these findings, it appears that mindfulness can impact cognition and affect in a therapeutic manner for individuals experiencing distressing auditory hallucinations.

There is, however, some literature which cautions against the use of mindfulness meditation with individuals in the acute phase of psychosis (Deatherage, 1975; Yorston, 2001). In response, some researchers have suggested that these studies were “methodologically weak” (Abba, Chadwick, & Stevenson, 2008). Despite these cautions, there is a growing body of literature which suggests that with appropriate modifications, mindfulness-based treatment interventions can be used successfully with this population (Bach & Hayes, 2002; Chadwick, Newman-Taylor & Abba, 2005; Gaudiano & Herbert, 2006).

A promising direction in the treatment of psychosis has come out of more recent psychotherapy models which incorporate acceptance and mindfulness principles into a cognitive-behavioral theoretical framework (Gaudiano & Herbert, 2006). Cognitive behavioral and mindfulness approaches are compatible because they share in the assertion that “distress and suffering result from the mind rather than directly from sensations or events” (Chadwick, 2005, p. 351). Therapeutic approaches which integrate cognitive-behavioral therapy and mindfulness include MBSR, MBCT, Dialectical-Behavior Therapy (DBT; Linehan, 1993), and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999). Of these therapeutic approaches, ACT, and modified MBSR and MBCT approaches have been the most studied in the treatment of psychosis.

ACT is based on the premise that many maladaptive behaviors are generated out of attempts to avoid or suppress thoughts, feelings, or physiological sensations (Hayes, Wilson,

Gifford, Follette, & Strosahl, 1996). Within the ACT framework, clients are encouraged to accept their reactions and to be present in the here-and-now, to choose a direction based on their personal values, and to take action toward accomplishing a goal (Didonna, 2009). The primary difference between ACT and more traditional forms of CBT is that rather than teaching people how to better control their thoughts, feelings, and physiological sensations as is done in traditional CBT, ACT aims to teach people to “just notice” and accept these experiences. Thus, ACT is strongly rooted in the belief that with increasing acceptance, one will achieve greater psychological health and well-being (Didonna, 2009).

ACT has been demonstrated to be an empirically-supported treatment approach for a range of clinical concerns. However, researchers have just recently begun to evaluate its efficacy in the management of psychosis. Bach and Hayes (2002) conducted a study in which 80 inpatient participants experiencing positive symptoms of psychosis were randomly assigned to treatment as usual (TAU) or to four sessions of ACT as an adjunct to TAU. The TAU condition involved pharmacological therapy, weekly participation in 3 psychoeducational groups, and weekly individual psychotherapy. In addition to these services, those selected for the ACT condition received four 45-50 minute, individual ACT sessions. The researchers found that four sessions of ACT reduced the rate of re-hospitalization over a four month period by 50 percent. Individuals who received the ACT treatment were more likely to report experiencing symptoms which served to reduce their rate of re-hospitalization by three times. The ACT group participants also demonstrated a lower rate of symptom believability. The researchers contend that the reduction in the believability of symptoms observed in the ACT group likely resulted from the participant’s increasing ability to experience the sensations without fear, thus facilitating greater objective observation.

Gaudio and Herbert (2006) expanded upon the aforementioned study conducted by Bach and Hayes (2002). The study included 40 inpatient participants experiencing psychotic symptoms. The patients were designated “high-risk” because of their symptom severity and high comorbidity. The participants were randomly assigned to one of two treatment conditions. The first condition was the enhanced treatment as usual (ETAU) which involved enhanced routine care in consideration of the participant’s high-risk status. TAU consisted of psychopharmacological therapy, case management, and on-unit individual and group psychotherapy. Enhancements TAU involved a comprehensive psychiatric evaluation as well as daily, brief supportive therapy. In addition to TAU, those assigned to the ACT condition received approximately three sessions each of ACT. The sessions were provided on an individual basis and were each one hour in duration. The researchers reported that the ACT group demonstrated greater improvement on measures related to affective severity, subjective distress, and social functioning as compared to the ETAU group. Further, the ACT group showed greater clinically significant overall symptom improvement. At a four month follow-up it was found that 28% of the ACT participants had been re-hospitalized whereas 45% of those in the ETAU had been re-hospitalized. These re-hospitalization rates are consistent with those found by Bach and Hayes (2002). Also consistent with previous research, symptom believability significantly decreased among the ACT group participants, but not among those in the ETAU condition.

The two previously discussed studies evaluated the use of mindfulness-based therapeutic approaches provided on an individual basis; however, research also supports use of mindfulness-based interventions provided in a group modality. For example, Chadwick (2005) assessed the clinical utility of an outpatient mindfulness group for individuals experiencing subjectively

distressing psychosis. Participants included 15 adults experiencing psychotic symptoms. All participants were also receiving psychopharmacological therapy concurrent with the group. The researcher adapted MBSR and MBCT in an effort to minimize the risk of harmful effects among the participants. Pre and post testing demonstrated a general improvement in overall functioning. Furthermore of the 11 people who completed the six week mindfulness group, six selected to participate in a second group. This suggests that the majority of participants did not find the group harmful. In addition, rankings of therapeutic factors demonstrated that mindfulness was subjectively more important than other therapeutic factors.

Chadwick, et al. (2009) expanded upon the study conducted by Chadwick (2005) assessing not only functional improvement among participants in a mindfulness group, but also assessing for changes in participant's mindfulness. The group was comprised of individuals experiencing active psychotic symptoms. Participants attended mindfulness training sessions twice weekly over a five week period, while also practicing at home with guided CD's. The post-treatment follow-up measures were administered after an additional five weeks of home practice following the mindfulness group. The researchers replicated their previous finding which showed an overall significant reduction in general symptoms. They also found a significant improvement in participant's mindfulness of distressing thoughts and images. Furthermore, the participants ranked mindfulness practice and universality (recognition that others experience similar problems) as the most beneficial therapeutic process factors. Thus, the researchers conclude that mindfulness-based treatment interventions are safe and therapeutic for individuals struggling with subjectively distressing psychotic symptoms.

Mindfulness-based treatment interventions are highly amenable to a group therapy format; therefore, they are particularly well-suited for use in inpatient settings as group therapy is

often the primary therapeutic modality of psychological services in inpatient settings. This is likely due its time and cost effectiveness. Group therapy has also been demonstrated to have good compliance rates and is well tolerated even by individuals under a significant level of distress or psychiatric disturbance (Mason & Hargreaves, 2001). Jacobson, Morris, and Johns (2011) assessed the feasibility of conducting and evaluating a mindfulness group at an inpatient psychiatric hospital for individuals with chronic, treatment resistant psychosis. The group was open to anyone experiencing distressing symptoms of psychosis as long as they were stable enough as to not disturb other participants. All participants were concurrently utilizing psychopharmacological therapy. Group attendance ranged from 3 to 5 participants each week, with each participant attending an average of 3 sessions. The group program was modeled after Chadwick (2005) and included facilitated group discussion and two 10-minute breathing meditations. Each participant was also provided with a mindfulness CD and was encouraged, but not required, to use the CD to practice outside of group. Based upon the findings, the researchers contend that it is possible to run a mindfulness group in an inpatient setting wherein participants are experiencing chronic, distressing, and treatment-resistant psychosis. Specifically, the data suggest that this patient population can tolerate short sitting meditations, reflect on such experiences, and relate them to everyday life.

In addition to investigating efficacy, recent research has examined the reactions of individuals who participated in a mindfulness group. For example, Winship (2007) assessed participant's reactions to a mindfulness group within an acute inpatient setting. The group provided in an open format. Participants met weekly for one hour with an average of five participants each session. Facilitators were also available for individual support services between group sessions when needed. Some participants, but not all were experiencing active

psychotic symptoms. The group facilitators utilized various mindfulness techniques in an effort to promote concentration and awareness of physiological sensations and mental processes. Techniques included sitting and walking meditations, with mindful breathing being a central skill. Group reflection and discussion followed each practice session. Participants reported an increased ability to separate themselves ('self') from their disturbing thoughts and feelings. The participants also reported increased concentration. In addition, all study participants described mindfulness practice as providing them with a sense of peace and relaxation, despite often experiencing significant psychiatric symptoms during their practice. Thus, the qualitative results of this study suggest that mindfulness can be a useful therapeutic endeavor in an inpatient psychiatric setting.

York (2007) conducted a study which evaluated the qualitative outcomes of a mindfulness group conducted at an inpatient psychiatric hospital. Although not all, some of the participants were experiencing psychotic symptoms. The researcher reported that participants claimed to have gained the ability to tolerate and accept difficult thoughts, feelings, and images with greater ease. In addition, participants reported gaining peace of mind and a sense of calm through their participation in the mindfulness group.

Abba, Chadwick, and Stevenson (2008) conducted a grounded theory analysis of 16 participants with psychosis who participated in an outpatient mindfulness group. The researchers found that through mindfulness these individuals learned to relate to their psychotic symptoms differently. Specifically, participants were able to regain a sense of power over their symptoms by opening their awareness to the symptomatic experience and allowing them to be without reacting. Participants learned to see and accept the experience of "voices, thoughts, and

images for what they are: unpleasant, transient sensations that form but one part of the person's experience" (Abba, Chadwick, & Stevenson, 2008, p. 84).

In summary, individuals with psychotic disorders often experience chronic and debilitating effects. In many cases, those with psychotic illnesses continue to have psychotic symptoms despite medication compliance. Rates of re-hospitalization are high among this population which comes at a significant cost to individuals and families affected by these illness, as well as to society as a whole. Thus, the need for more effective psychosocial interventions is needed. The use of cognitive-behavioral treatment interventions with this population has received empirical support. However, concerns regarding CBT's emphasis on interventions aimed at controlling the experience of psychosis through efforts such as distraction have been raised. In addition, there have been few randomized controlled trials using CBT within an inpatient setting.

The use of mindfulness has received growing attention as a potentially effective means of intervention with patients experiencing active psychotic symptoms. The primary goal of using mindfulness-based treatment approaches with this population is to teach these individuals how to relate differently to their symptoms, such that they are able to observe psychotic symptoms as transient experiences, without judging them. This is done in an effort to reduce one's subjective distress. Although there is some literature that cautions against the use of mindfulness meditation with individuals in the acute phase of a psychotic illness, more recent literature suggests that mindfulness-based interventions can be successfully modified for use with this population. There is a growing body of literature which demonstrates the efficacy of mindfulness-based treatment interventions provided in group and individual formats, as well as in outpatient and inpatient settings for individuals with psychosis. The available literature

suggests that the use of mindfulness with individuals with psychosis can facilitate a decrease in overall symptoms, and can promote a reduction in subjective distress and the believability of symptoms. Mindfulness has also been shown to provide participants with a sense of calm and relaxation, while also instilling a sense of power over their experience. Thus, the available research suggests that mindfulness-based treatment interventions may be an effective adjunctive treatment approach for individuals with psychotic illnesses.

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