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Cognitive Behavioural Relating Therapy (CBRT) for Voice Hearers: A Case Study

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Background: There has been a recent focus on the interpersonal nature of the voice hearing experience, with studies showing that similar patterns of relating exist between voice hearer and voice as between voice hearer and social others. Two recent therapeutic approaches to voices, Cognitive Therapy for Command Hallucinations and Relating Therapy, have been developed to address patterns of relating and power imbalances between voice hearer and voice. **Aims:** This paper presents a novel intervention that combines elements of these two therapies, named Cognitive Behavioural Relating Therapy (CBRT). **Method:** The application of CBRT is illustrated through a clinical case study. **Results:** The clinical case study showed changes in patterns of relating, improved self-esteem and reductions in voice-related distress. **Conclusions:** The outcomes provide preliminary support for the utility of CBRT when working with voice hearers.

Keywords: Auditory hallucinations, voices, cognitive behaviour therapy (CBT), social rank, schema, interpersonal relationships.

Introduction

Extending traditional cognitive behavioural models of voices, Birchwood and colleagues (Birchwood, Meaden, Trower, Gilbert and Plaistow, 2000) theorized that the social processes that guide interpersonal interactions also govern the relationship between voice hearer and

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voice. Since then, numerous studies have sought to understand patterns of social relating in voice hearers (see recent literature reviews: Hayward, Berry and Ashton, 2011; Paulik, *in press*). Two well replicated findings have emerged from this literature. First, voice hearers who perceive themselves to be inferior (or of “low social rank”) relative to others also feel inferior in relation to their voice, and behave accordingly. Second, responding to voices from a position of closeness is associated with least distress. These findings have contributed to the development of two different therapies for voice hearers, both targeting the power imbalance in the voice-hearer relationship but through disparate mechanisms. Trower and colleagues (2004) developed cognitive therapy for command hallucinations (CTCH), which aims to reduce compliance and voice-related distress by modifying beliefs about voices, including perceived voice power. Hayward, Overton, Dorey and Denney (2009) developed Relating Therapy (RT) for voice hearers, which aims to improve the voice-hearer relationship by increasing reciprocity and closeness through assertiveness training and empty chair work. Both interventions have been shown promise in reducing voice-related distress.

Empirical studies have found the relationship between voice-related distress and closeness to be mediated or moderated by beliefs about voice malevolence and power (e.g. Sorrell, Hayward and Meddings, 2010). However, whilst beliefs about voices are influential in maintaining distress (Peters, Williams, Cooke and Kuipers, 2012), the extent to which they are amenable to therapeutic modification is unclear (Mawson, Cohen and Berry, 2010). These findings advocate a combined approach to treating voices. For instance, to start by challenging beliefs about voice intent and omniscience (using CBT techniques) so as to lessen the fear and avoidance of the voice(s), and subsequently to facilitate responding to the voice from a position of uprightness and closeness through assertiveness training and empty chair work.¹ This paper introduces an intervention that brings together elements from both CTCH and RT, named Cognitive Behavioural Relating Therapy (CBRT) for voices.

The primary aims of CBRT are: (1) to improve the relating of the hearer, both relative to their voices and to social others; and (2) to decrease voice related distress and negative affect. The four main components of CBRT are: (1) formulation; (2) CBT for assertiveness-interfering thoughts/beliefs; (3) assertiveness training; and (4) self-esteem work. This paper describes the core mechanisms of CBRT and illustrates its application using a clinical case study.

Method

Participant

Sally received CBRT as an outpatient at The Kiloh Centre, Prince of Wales Hospital (Sydney, Australia) as part of a Quality Improvement project. Sally was a single woman in her late thirties who first experienced voices and was diagnosed with schizophrenia aged 26. She was in a stable phase of illness, though had recently been hospitalized for depression following the death of her mother. She was taking a depot injection of zuclopenthixol decanoate (250mg) monthly. In the past, her voices corroborated her paranoid delusions, but she denied them

¹ See the extended version of this manuscript for additional potential benefits of combining CTCH and RT.

ever being abusive. Sally reported currently hearing three voices: two voices of elderly ladies (one that started around the time of her mother's death) and a voice of a female around her own age. The voices typically made neutral comments or suggestions. She found her voices distressing because they were "intrusive" and made her feel "crazy". She reported having a happy childhood and being a high achiever. Her father passed away when she was young. Sally described her mother as intrusive, over-involved, controlling, and attention demanding, but also a close friend in her final years.

Measures

All measures were completed at baseline and one week after the final session. The *Psychotic Symptoms Rating Scale – Auditory Hallucinations* (PSYRATS-AH; Haddock, McCarron, Tarrrier and Faragher, 1999) was administered to measure voice severity and distress. The *Voice Power Differential (VPD) Scale* and the *Social Power Differential (SPD) Scale* (Birchwood et al., 2000) were administered to measure the perceived power of self relative to the voice and social others, respectively. The *Depression Anxiety and Stress Scale-21* (DASS; Lovibond and Lovibond, 1995) was administered as a state (the "past week including today") measure of negative affect. Self-esteem was assessed using the *Rosenberg Self-Esteem Scale* (RSES; Rosenberg, 1965) and functioning was assessed using the *Social and Occupational Functional Assessment Scale* (SOFAS; Goldman, Skodal and Lave, 1992). All scales have good reliability and validity.

Procedure and intervention

Sally gave informed consent to participation within this study. The extent and limits of confidentiality were fully discussed. CBRT consists of two assessment sessions (one on voice hearing, the other on past and present relationships) and 12 weekly, 50-minute individualized therapy sessions. All steps in therapy are applied to both the client's relationship with her voices and social others.

The first therapy session is spent developing a relapse prevention plan, including the identification of short-term strategies for coping with distressing voices. Sally responded positively to this session, and extended her limited repertoire of coping strategies. The second session is spent doing joint formulation. Here the therapist draws parallels between the client's relationship with her voices and with significant others. Sally noted two parallels between the older voices and her mother: the intrusive nature, and the edifying yet caring nature. Sally found this latter observation startling and later comforting. The concept of "relationships" and the capacity for relationships to change is also discussed in this session, with the aim of the client accepting she has a relationship of sorts with the voice, and to empower the client to view herself as an agent for change in her relationships. This dialogue leads to the rationale that increasing assertiveness may help to improve self-esteem and foster a pattern of more equal relationships. Sally was resolute that she did not have a "relationship" with her voices. Using downward arrow technique it became apparent that this was tied to her belief that "if I engage with my voices then I am crazy". Further discussion around the term "relationship" helped to weaken her conviction.

The aim of session three is to provide education around assertive, passive and aggressive styles of communication, using discussion and role-play. Homework is set to monitor the

client's communication styles. In this session, Sally identified herself as being a passive communicator and her mother, sister and voices as switching between aggressive and assertive communicators.

Sessions four to six focus on challenging assertiveness-interfering beliefs using CBT techniques. The monitoring homework can be used to identify beliefs to target, such as "my voice will hurt me if I disagree with it" or "others will perceive me as rude if I behave assertively". In these sessions, the evidence for and against Sally's belief that "if I engage with my voices I will become unwell" was examined. Slowly, Sally tested this belief by engaging with her voices and found that it did not induce other psychotic symptoms or make her feel "crazy". By the final stages of therapy, Sally reported finding her contact with her voices "somewhat comforting".

Sessions seven to ten focus on assertiveness training. Techniques used include: (1) teaching skills of assertiveness; (2) experiential role plays; (3) empty chair work; and (4) the development and implementation of an assertiveness exposure hierarchy. Sally found this latter step challenging as her ratings of anxiety were polarized. All assertiveness situations thought of were rated by Sally as either 20/100 (minimal anxiety) or 100/100 (maximum anxiety), limiting the ability to do graded exposure. Similarly, Sally was resolute that she did not want to tackle those situations rated at 100/100 for anxiety, as she did not wish to be *that* assertive. Although this was never resolved, Sally completed all early steps in the exposure hierarchy, and reported feeling happier that she could assert herself in everyday situations and with her voices.

The focus of sessions 11 and 12 is on self-esteem. Session 11 is on Building Mastery. Sally was able to develop an extensive list of previously mastered skills, though found it more difficult to commit to new mastery goals. She set and completed two goals – cooking "the perfect steak" and learning to play online chess – which she reported to be proud of achieving. In session 12, the client commences the "Positive You Journal" with the therapist (see the self-esteem manual at: www.cci.health.wa.gov.au). To Sally's surprise she was able to construct a long list of her positive qualities.

Results

At her post-therapy assessment, Sally gave feedback on her experience of CBRT. She reported finding it helpful to discuss her voices with someone who understood her experiences. She reported continuing to engage with her voices and finding them less intrusive and distressing. Although her depression was still rated as "severe" on the DASS, Sally said she felt happier about herself now that she could assert her needs on a day-to-day basis. Sally also commenced a Hearing Voices Network group at the conclusion of therapy, which she previously felt she could not do.

Sally's scores changed in the desired direction for all measures (see Table 1), with the exception of her perceived power relative to the voice and others. This lack of perceived power is somewhat inconsistent with the reported improvements in assertiveness and self-esteem, and may be associated with Sally's reluctance to engage with situations that were highly anxiety-provoking. Of note, there was a marked reduction in voice-related distress, depression, anxiety and stress, which were the primary targeted outcomes.

Table 1. Baseline and follow-up scores on the outcome assessment measures

Measures	Baseline	Completion
DASS-Depression	32/63 (ext. severe)	24/63 (severe)
DASS-Anxiety	12/63 (moderate)	0/63 (normal)
DASS-Stress	22/63 (moderate)	6/63 (normal)
Voice power differential ¹	14/35	19/35
Social power differential ¹	20/35	21/35
RSES (self esteem)	5/30	10/30
PSYRATS Total	24/44	16/44
PSYRATS Severity	7/12	5/12
PSYRATS Distress	7/16	2/16
SOFAS	35/100	50/100

¹Lower scores reflect the client having more power than the voice/others
Notes: DASS = Depression Anxiety and Stress Scale; RSES = Rosenberg Self Esteem Scale; PSYRATS = Psychotic Symptoms Rating Scale (Auditory Hallucinations); SOFAS = Social and Occupational Functioning Scale

Discussion

The case study illustrates the application of CBRT for voice hearers and its potential benefits. The therapy process was well received by the client, with Sally agreeing with the goals of CBRT and attending sessions regularly. Sally verbally reported improvements in her relationship with her voices and others, and reductions in voice-related distress, and the latter were supported by measurement. These findings offer additional support for the utility of working from CBT and relational approaches with voice hearers (Trower et al., 2004; Hayward et al., 2009, 2011; Paulik, in press).

It will be necessary to pilot CBRT in a larger sample within a more robust design that includes a control condition, randomization, fidelity to the therapy protocol, and blind assessments. Follow-up assessments will also be required to measure the maintenance of any effects. A further issue for consideration concerns the sub-populations of voice hearers for whom CBRT and other relationally-informed therapies may be most beneficial.

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