

Editorial

Mindfulness for psychosis

Paul Chadwick

**Summary**

Mindfulness treatments and research have burgeoned over the past decade. With psychosis, progress has been slow and likely held back by clinicians' belief that mindfulness may be harmful for this client group. There is emerging evidence that mindfulness for

psychosis – when used in an adapted form – is safe and therapeutic.

Declaration of interest

None.

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Background and rationale

Mindfulness is a meditation practice that involves learning to observe sensations, and one's reactions to them, with clear, gentle and non-judgemental awareness, and in so doing to let go of self-defeating habitual reactions to difficult experience. Mindfulness-based theories and interventions have proliferated in recent years for a wide range of physical and mental health problems. Mindfulness for psychosis has lagged behind, with clinicians voicing concerns about its implementation. These concerns stem in large part from uncontrolled studies reporting an association between different forms of meditation practice (but not a contemporary mindfulness intervention) and deterioration in mental health in people either with, or vulnerable to, psychosis.

It might be asked, is mindfulness for psychosis needed when individual cognitive-behavioural therapy (CBT) is already recommended by the National Institute for Health and Care Excellence (NICE)?¹ First, it has long been observed that people with psychosis who report coping better typically describe a more accepting attitude towards, and a capacity to disengage from, their experiences – two mechanisms that take centre stage in mindfulness interventions. Second, mindfulness offers a means to ease distress and disturbance associated with voices and paranoia, without the need to discuss and question content of beliefs. Third, mindfulness interventions are typically delivered in groups, where there is no NICE recommended talking therapy for schizophrenia. Fourth, leading theories of psychosis implicate a tendency to attribute excessive salience to certain internal and external stimuli, such that they come to 'grab attention' and 'drive action':² mindfulness practice directly reduces the tendency to have attention locked on stimuli that are difficult or personally meaningful. And crucially, person-centred care and preference, cornerstones of NICE recommendations, presume a choice of evidence-based therapies, as is the case for example with medications for psychosis or psychological therapies for depression.

Adapting mindfulness for psychosis

Our work began with the question, 'How does mindfulness need to be adapted so as to be safe and therapeutic for people experiencing psychosis?' Clear answers are emerging, some

examples of which follow. Most strikingly, for many people who experience distressing voices, paranoia, images, etc. (and will experience them during meditation), 10 min of practice, and not the traditional 40, is their limit. This points to a second distinctive feature, namely that the guidance during meditation needs to be every 30–60 s, without long silences, to prevent people becoming lost in a struggle with malevolent voices or in paranoid ruminations. Also, guidance during meditation needs to refer explicitly to the psychotic sensations, and to do so in a normalising way, giving them no special status above other sensations that arise and pass – this begins subtly to question the perceived omnipotence of voices,³ a crucial early focus in psychological interventions for distressing voices.

Published pilot studies indicate that in this adapted form, mindfulness is safe and beneficial for people with distressing psychosis. First, though, it is important to be clear about primary outcome. Symptom reduction or elimination is not the primary aim. The premise behind mindfulness interventions for any disorder is that even when symptoms persist, people can learn to respond to them differently and thus be less distressed and disabled by them. With mindfulness for psychosis, the primary outcome needs therefore to measure general psychological well-being, and not occurrence of symptoms – indeed, the same has been argued in relation to CBT for psychosis.⁴ One such widely used measure in the UK is the CORE (Clinical Outcomes in Routine Evaluation), an outcome assessment tool developed specifically for the psychological therapies. We have published three pilot studies^{5–7} involving more than 80 people with distressing voices, or paranoia, or both, and each found a statistically significant pre–post improvement on CORE following groups using either mindfulness alone or mindfulness integrated with CBT.

Processes of change are also becoming clearer. In a qualitative study,⁸ the first 16 people who attended our mindfulness groups described how learning to recognise and gently let go of habitual self-defeating reactions to psychosis led to a feeling of reclaiming power from difficult voices and thoughts, and to increased acceptance of both themselves and their psychotic experience. The study also revealed the importance of new understanding, or metacognitive insight, in the change process, as participants discovered that *how* we respond to difficult sensations makes all the difference. (Interestingly, traditional psychiatric insight is not necessary for people to engage with mindfulness: for example, many people learn to respond mindfully to voices they still firmly believe to be another person or being.) None of the 16 people reported any negative consequences of mindfulness practice. Finally, although our outcome research indicates that clinical benefit is associated with increased mindfulness skills, participants subjectively assessed the non-specific group process of

universality⁹ (discovering that I am not alone, that others have similar problems) to have been as helpful as learning mindfulness.^{5,6} Thus, group factors need to be borne in mind when running mindfulness for psychosis groups, and their contribution weighed in outcome research.

Future directions

Enthusiasm for mindfulness is at such a pitch that there arises a danger that the psychosis field moves from arguably too little happening to too much. To reiterate, although the evidence base for mindfulness for psychosis is growing, it still is based on small pilot studies, and there is a need for more evidence, derived from both well-controlled outcome trials and routine clinical practice. Research has yet to examine whether clinical improvement is mediated by mindfulness skills, acceptance (of psychosis and self) or metacognitive insight. Also, in relation to distressing voices, does mindfulness reduce perceived voice omnipotence? Again, neuroscience is pointing towards possible mechanisms worthy of investigation, such as functional connectivity between the default mode network regions involved in self-referential processing and emotional appraisal, especially the medial prefrontal cortex and the posterior cingulate. Moreover, it needs to be borne in mind that the breakthrough studies were conducted by clinicians experienced and skilled in mindfulness, in psychological therapy, and in working with people with psychosis – so adequate training and supervision become critical as findings are translated into wider clinical practice.

The intention behind this editorial is to argue that there is now sufficient published research, backed up by considerable clinical experience, to encourage careful clinical practice and research exploring the efficacy and effectiveness of adapted

mindfulness interventions for people struggling to cope with psychotic experience.

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