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Building a Grounded Theory of Engagement in Mindfulness-Based Group Therapy for Distressing Voices

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Abstract

Mindfulness based group therapy shows promise as a treatment for distressing voice-hearing. However, fostering engagement in groups can be challenging, and no theory of engagement in group therapy for distressing voices exists to guide practice or research. This study employed Grounded Theory Method to build a theory of engagement in mindfulness based groups for distressing voices. Ten service-users and three therapists were interviewed about their experiences of such groups. The model that emerged involves a recursive process of investing in change and continually evaluating its usefulness and safety. Barriers to engagement were often overcome, but sometimes compromised perceived safety, leading to dropout. For others, group participation led to rewards, some of which were integrated beyond group termination. Group engagement can be encouraged by establishing universality around voice-hearing early, reducing uncertainty, sharing difficulties with mindfulness practices and mapping group progress to create a cohering sense of collaboration on therapy tasks.

Keywords: mental health and illness; mindfulness; voice hearing; engagement; psychological issues; psychology; therapies; qualitative; grounded theory method; United Kingdom

Introduction

Auditory verbal hallucinations, (or "voices"), commonly feature in psychotic conditions like schizophrenia (American Psychiatric Association, 2013), and a range of other conditions including borderline personality disorder (Slotema et al., 2012) and post-traumatic stress disorder (Butler, Mueser, Sprock & Braff , 1996). A literature review found a median estimate of the prevalence of voice hearing in the general population of 13.1% (Beavan, Read & Cartwright, 2011). The experience of voice hearing appears similar across diagnostic and nonclinical groups (Daalman et al., 2011; Slotema et al., 2012) and may or may not cause distress and disrupt functioning (Romme and Escher, 1993). Given this, a symptom-based approach to understanding voice hearing, its associations with distress and disturbance, and therapeutic interventions has been called for (Thomas et al., 2014).

The dominant approach used to work with distressing voices to date has been Cognitive Behavioural Therapy for psychosis (CBTp). However, access to CBTp remains limited. A recent audit of UK community mental health teams found that only 7% to 20% of eligible service-users had been offered CBTp (Prytys, Garety, Jolley, Onwumere, & Craig, 2011). This shortfall in provision of CBTp is partly attributable to an insufficient number of trained therapists (Berry & Haddock, 2008). One way to improve access is to deliver CBTp in a group format allowing multiple service users to access therapy simultaneously. However, there is limited evidence for the effectiveness of group CBTp. Two well controlled trials found no significant effect of group CBTp on: severity of voices, positive symptoms, depression, anxiety or global functioning (Barrowclough et al., 2006; Wykes et al., 2005) compared with treatment as usual (TAU).

Research attention has therefore turned to developing and evaluating alternative group therapies to improve on these outcomes. Thomas et al. (2014) identified

mindfulness based interventions as one of the most significant areas of intervention development since CBTp. While Acceptance and Commitment Therapy (ACT), which involves a mindfulness component, has been developed in a group format for psychosis (Johns et al., 2015), ACT does not meet criteria that have been outlined by leading researchers to define mindfulness-based programs (Crane et al., 2016) and group ACT for psychosis has not been adapted to work specifically with voice hearing, nor has the research on group ACT recruited transdiagnostic samples of voice hearers. The only mindfulness based group therapy to date that has been adapted to work specifically with distressing voice hearing is Person Based Cognitive Therapy (PBCT) (Chadwick, 2006). PBCT groups include the traditional CBTp focus on beliefs about voices' omnipotence and control but also worked across these four domains: (a) the meaning of the voice-hearing experience (b) the relationship between hearer and voice (c) positive and negative views of the self (d) self experienced as dynamic and changing. The evaluations of group PBCT for distressing voices that have been conducted to date have produced promising early findings on voice related measures (Chadwick et al., 2016; Dannahy et al., 2011). The only randomised controlled trial to date found that a 12 week PBCT group intervention produced significant improvements in measures of voice-related distress, perceived controllability of voices, recovery and depression compared with treatment as usual (Chadwick et al., 2016).

Given these promising findings and the limited evidence for group CBTp's effectiveness, further research is warranted to into the ability of mindfulness based group therapy to treat distressing voice hearing and address the resource challenge described earlier. Engaging and retaining service users in group therapy is challenging and group engagement, whether measured through dropout rate, session attendance, homework compliance, or in-session measures of engagement, has been shown to predict outcomes across therapy modalities and with various client groups. Clients who terminate therapy prematurely, report

less therapeutic progress and more psychological distress (Pekarik, 1992). Unlike individual therapy, poor group attendance may impact on others, by contributing to an "absence culture" (Gellatly & Luchak, 1998) or leaving other group members feeling insecure, worried, or angry (MacNair & Corazzini, 1994). Research has shown that homework compliance in group CBT and exposure task compliance in behavioural therapy are associated with reduced symptom severity at follow-up (Neimeyer, Kazantzis, Kassler, Baker & Fletcher, 2008; Schmidt & Woolaway-Bickel, 2000). Furthermore, "engagement" as measured by the Group Climate Questionnaire (GCQ) (MacKenzie, 1981), is moderately to strongly correlated with outcome (McClendon & Burlingame, 2010). "Engagement" as measured by the GCQ captures: "a positive working atmosphere where members self-disclose, confront, care about and support one another" (Thorgeirsdottir, Bjornsson & Arnkelsson, 2015, p.203). A systematic literature review found no research to date on engagement in mindfulness based group therapy for distressing voices.

There may be engagement processes specific to mindfulness based groups for distressing voices. A systematic review of mindfulness based interventions for distressing voice hearing found that while participants viewed mindfulness practices as safe and acceptable as part of therapy, including in a group format, a minority of participants were distressed by mindfulness practices (Strauss, Thomas & Hayward, 2015). There is no research to date to tell us what impact this distress had on participants' engagement and what might facilitate a good outcome for the minority of participants who are distressed by mindfulness practices. In terms of dropout from mindfulness based group therapy for distressing voices: in the PBCT trial discussed earlier, 72% of participants attended at least eight sessions and were regarded as "completers" and in the uncontrolled pilot evaluation of PBCT, 19% of participants failed to attend at least six sessions (Dannahy et al., 2011).

Historically, research on group engagement has focused on predicting later group attendance given various baseline characteristics. However, this research has produced inconsistent results and replication failures (Wierzbicki & Pekarik, 1993). Therefore research attention has turned to in-group correlates of engagement. Much of this research has drawn on Yalom and Leszcz's (1967, 2005) theorised eleven therapeutic factors of group therapy and investigated relationships between these factors and group engagement. For example Hand, Lamontagne and Marks (1974) found they could engender group cohesion by encouraging co-operation between clients on the tasks of therapy, and cohesion was positively correlated with outcomes and engagement. Randomised trials have compared engagement between types of group, and tested interventions designed to improve engagement. However, these trials all found large variation in engagement within and between groups that was not accounted for by the variables theorised to affect engagement (Bakali et al., 2013; Blake, Owens & Keane, 1990; Delsignore et al., 2016). Therefore this literature leaves much unknown about engagement processes in any group therapy, let alone mindfulness based groups for voice hearing. This is perhaps unsurprising given the complex nature of group processes. It is likely that a complex interplay of causal relationships that vary under differing conditions is operating (Paquin & Kivlighan, 2016). These complexities can be usefully investigated through qualitative designs.

Grounded theory method is a qualitative methodology well suited to investigating complex, dynamic social processes (Urquhart, 2012) such as group engagement. Grounded theory method can be used to generate theory in poorly understood areas such as engagement in mindfulness based groups for distressing voice hearing.

A systematic literature search found no grounded theory that was applicable to voice hearers engaging in mindfulness groups (or indeed any other form of group therapy). Given this, the aim of the present study was to build a grounded theory of engagement in

mindfulness groups for distressing voice hearing. To date PBCT is the main mindfulness based group approach that has been used with psychotic experiences. Therefore this study aimed to recruit therapists and clients with experience of PBCT groups. There is some evidence that the process of dropping out of established psychotherapy groups may be damaging (Stiwne, 1994). Despite its potential clinical utility, a systematic literature found no studies on engagement that elicited the experiences of those who had dropped out of group therapy for mental health problems. Furthermore, a recent systematic review and a recent qualitative synthesis of literature on experiences of psychological therapies for psychosis has called for more studies to recruit those who do not engage with, or drop out of therapy (Holding, Gregg & Haddock, 2016; Wood, Burke & Morrison, 2013) Given this, the present study specifically aimed to elicit the experiences of those who had dropped out of a PBCT group. Given this, the present study specifically aimed to elicit the experiences of those who had dropped out of a PBCT group.

Method

Design.

Grounded theory method, following the procedures outline by Corbin and Strauss (2008) was used to generate and analyse data. A critical-realist epistemological stance was adopted in planning the research. A critical-realist stance views the process of data generation as one of co-creating a narrative of experience that corresponds to an objective reality to an unknowable extent.

A semi-structured interview schedule (see Appendix A) was developed in consultation with the research supervisors and a trust service user advisory group. The interview topics included: worries and hopes before starting the group, facilitators and barriers to engagement, and thoughts about carrying learning forward after group completion. Interviews were guided by the use of open questions and prompts. However, a person-

centered interview style was adopted to elicit the personal concerns of participants (Wimpenny & Gass, 2000).

Procedure

Participant recruitment.

All participants were involved, as therapists or clients, in a 12-session PBCT group for distressing voice hearing (Chadwick, 2006) in an NHS trust in the South of England. The group intervention was embedded in a stepped-care model. All patients referred to the clinic received four sessions of coping strategy enhancement prior to group therapy (CSE) (Tarrier, 1990). CSE explores service-users' existing coping strategies for dealing with distressing voices and supports them to apply these more systematically.

All service-users from two PBCT groups (N=16) were approached by clinic research assistants during routine appointments and were given participant information sheets. Those who indicated interest in the study were contacted by the first author. Informed consent was sought immediately prior to the interviews. Theoretical sampling was used (Corbin & Strauss, 2008). Two participants who dropped out of therapy were recruited after the initial round of interviews to broaden the theory's explanatory power. Both of these service-users had indicated they were happy to be contacted again by the clinic for research purposes, and agreed to participate.

The first author contacted potential therapist participants directly. The first author answered questions about the study over the phone and arranged research interviews with interested therapists.

Data Generation.

Interviews were conducted over eight months with participants whose last group attendance was between zero and 18 months prior to interview. Two service-users were

interviewed twice, six months apart. This was done to explore emergent hypotheses from early analysis of these participants' data, and to ask confirmatory questions. (Corbin and Strauss, 2008). Interviews lasted between 15 and 71 minutes (mean= 34 minutes). In keeping with the grounded theory method principle of theoretical sampling, the interview schedule was revised to explore emergent hypotheses after early data generation and analysis from the first six interviews (Corbin and Strauss, 2008). This process was done in consultation with a group of service-user advisors who had previously engaged with interventions in the voices clinic and meet regularly to advise on service development in the host NHS trust. The advisors gave their views on the early analysis and suggested avenues to explore in the revised interview schedule. Recruitment stopped when theoretical saturation had been reached on all categories except "dropout". This is because it was not possible to recruit more participants who had dropped out of a group by the end of the study period. Anonymised interview transcripts are now held securely by Salomons Centre for Applied Psychology.

Participants

Inclusion/Exclusion criteria.

Eligible service-user participants were experiencing auditory hallucinations at the time of intervention, as measured by scoring four or above on item P3 of the Positive and Negative Syndrome Scale (PANSS) (Kay, Flszbein & Opfer, 1999). The hallucinations must also have been causing significant distress, as indicated by scoring 3 or above on one of the distress items of the Psychotic Symptoms Rating Scale (PSYRATS) (Haddock, McCarron, Tarrier & Faragher, 1999). The voices clinic adopts a transdiagnostic approach and service-users were not excluded on the basis of diagnosis. Group therapists were eligible if they had facilitated at least one PBCT group within two years prior to participation.

Participant characteristics.

13 people participated in the study, ten service-users and three group therapists. This is comparable to participant numbers in published grounded theory studies of CBTp (for example McGowan & Lavender, 2005). The participants were aged between 24 and 68 (patient mean = 41, therapist mean=41). Nine service-user participants were hearing voices and one was distressed by hearing music. All service-users were receiving standard psychiatric care, including medication. Three dropped out of a PBCT group and seven completed, attending at least nine sessions. All therapists were clinical psychologists who facilitated separate PBCT groups.

Ethical considerations

Ethics approval for the study was obtained from the NHS Fulham Research Ethics Committee in January 2016 (REC reference: 16/LO/0045). Capacity to consent was checked by asking participants to explain their understanding of the benefits and risks of participation immediately prior to beginning the interviews and to talk through their decision to participate in light of these. The first author, who conducted the interviews and analysis, was not involved with service-user care in the clinic, nor had he any authority over therapists. The author discussed the risk that the interviews could cause distress with participants beforehand, offered breaks during the interview and adopted a warm, person-centred interview style to minimise the risk of causing distress. To ensure participant confidentiality, names and pseudonyms were stored separately from all other data in a locked cabinet. Interviews were recorded on an electronic voice recorder and transferred immediately after interview on to an encrypted and password protected memory stick approved for use in the NHS

Data analysis.

The data were analysed in keeping with methods outlined in Corbin and Strauss (2008). The software package NVivo 10 was used for managing and analysing the data. In

keeping with grounded theory method principles, data analysis ran concurrently alongside data generation. After every one to three interviews, transcription and coding took place. The first four interviews were open coded, line by line, to sensitise the author to the range of potential meanings in the data and develop concepts. Concepts were grouped and higher order categories began to emerge. The categories' properties and dimensions of interest were then developed. Axial coding was used to elucidate relationships between categories and sub-categories along their properties and dimensions. As the core category of interest began to emerge, selective coding was undertaken to densify categories and specify their relationships to the core category.

'Constant comparison' (Glaser & Strauss, 1967) was used throughout the analysis to compare data instances, codes and categories with one another. Memo writing and diagramming were used to develop concepts and relationships between concepts.

Quality assurance methods

Elliott, Fischer and Rennie's (1999) guidelines for qualitative research were followed to ensure quality control. "Owning one's perspective" was scaffolded by keeping a reflective diary throughout data generation and analysis and by theoretical memoing in relation to personal perspectives on, and emotional reactions to the data generated. The author's epistemological and theoretical perspectives are discussed in the next section. "Grounding in examples" was achieved by producing a table, which grounds all the open codes with example quotes, and a coded transcript, which were audited by independent researchers. The "credibility" of the codes and category development was audited by the study supervisor.

Theoretical orientations and personal anticipations.

At the time of data collection I had experience of working clinically in the voices clinic, delivering CSE. I undertook a scoping literature search before forming the project proposal. These experiences and learning meant I anticipated a powerful role of group

common factors (Yalom & Leszcz, 2005). For example I anticipated that participants would be encouraged to engage with the group process after experiencing a sense of universality around voice hearing experiences early in the group development.

Results

[Figure 1. Near here]

Overview of the model

Figure 1 is a model of the process of engaging in mindfulness based group therapy for distressing voices. Categories and sub-categories are presented in Table 1 and are highlighted in the text in bold. The model depicts a recursive process of **investing** in the group and **evaluating** it in terms of its **usefulness** and **safety**. If its **safety** in particular is **evaluated** to be lacking at any stage, this may lead to participant **dropout**. That said, the initial period of group engagement is often characterised by **flexibility in evaluation** and an **initial short-term commitment** i.e. **giving it a go.**

Investing and **evaluating** dovetail over time and do not follow a strict sequence. However, a few patterns generally seem to apply. Firstly, **safety** is more important to participants in earlier stages. Secondly, participants initially **evaluate** the **usefulness** of the group on relevant past experiences and their **hopefulness in the clinic** approach. Later they use direct experiences of **seeing it work** for themselves and/or other group members. **Working** in the group, by **learning** and **incorporating the group into life**, can lead to various **rewards of engagement**, including **interpersonal rewards** and **seeing it work**. If group participants **expect rewards, notice them and link them to the group**, this particularly motivates ongoing **investment**.

Participants face various **barriers** to fruitful group engagement. **Managing these difficulties** can be achieved in a number of ways. However, these **barriers** can significantly impair fruitful engagement and impact negatively on **evaluations** of the group, particularly its **safety,** and thereby precipitate dropout. Participants' **responses to (group) ending** are various. Participants **integrate** some benefits into their lives, while others are **lost**. The categories contributing to the model will now be considered in more detail. Quotes will be used to exemplify the categories and sub-categories.

Core category.

The core category that emerged from the analysis was **"investing in changes that seem safe, manageable and useful".** This section will briefly summarise how the other categories relate to the core category and how it accounts for large variations in engagement. Some participants dropped out early (stopped investing) because they felt the group wasn't safe for them. Other participants kept coming back and working hard because they witnessed the group's usefulness. "Barriers" affect how manageable changes are and require extra investment or they will compromise safety/usefulness. Responses to ending can be seen as further investment in change and again this is influenced by personal barriers interacting with evaluations of safety.

INSERT TABLE 1 ABOUT HERE

Category A. Giving it a go

Participants described flowing with clinic expectations in the first instance. For example, *"…if they've gone to all this effort then you would go rather than not go"* This code captures the external nature of some participants' initial motivations. This was often a short-term commitment. For example, *"Part of me was not quite sure about this but I'll go to a*

couple and see what it's like". This initial investment allowed participants to gather more information with which to evaluate the usefulness and safety of the group. Many participants acknowledged suspending judgement until they had this information (a code under the sub-category 'flexibility in evaluating'). For example, *"I think just letting the experience just talking for itself rather than having too many preconceptions about how it's going to be was important for me"*.

Category B. Safety

Participants continuously evaluated how safe they felt in engaging with the therapy and this linked with their willingness to make ongoing investments. For example, *"I also really struggled with the mindfulness (...) I just completely dissociated (...) which was really frightening (...) I was asked if I wanted to continue (...) But that didn't really seem to me very worth doing".* Various factors compromised participants' sense of safety. Participants arrived with **worries about starting therapy.** Among other things, these worries were sometimes based on past experiences of services and sometimes on stigmatised attitudes about voice hearers, including themselves. Most reservations centred on interpersonal concerns, such as worrying about being judged, seeming crazy, performance anxiety, privacy concerns and encountering disruptive others. For example:

> (…) if other people would just be too ill or would disrupt the group somehow (…) and there was the concern that they would all be really lovely but (…) I would look like the wacky one of the group.

It was important in the early stages of therapy to **make the context feel safe.** Participants valued feeling held by caring clinic staff and by group boundaries being codified

in a written agreement. Participants were also reassured by the small group size and by being given explicit permission to leave the room if feeling anxious.

Participants varied in the specificity of their concerns before beginning therapy and some worried about encountering a new setting per se. Given this, strategies aimed at **reducing uncertainty** helped to build engagement. Specifically, participants welcomed the familiar NHS location, the consistent structure of sessions and the opportunity to 'size things up before jumping in'. For example, *"I sat there quite quietly, not talking really and just trying to size it, up what was going to happen."* Others felt there wasn't enough time to size things up and that led one participant to drop out. For example:

> It was kind of straight in to the relaxation thing (…) Maybe the first time you just, I don't know, have a cup of tea and maybe talk about what's going to happen in the future (…) I just couldn't do it.

The contrasting responses quoted above might suggest a differing sensitivity to threat among participants. For example, *"I think people were a bit shy and I'm not shy so I was just talking loads."* This contrasts with another group member's experience: "*Because with my borderline I have to always look at the door. I have to always feel safe. I know that I've got trust issues."* This difference among group members was useful since extrovert group members tended to lead the way. This **made the work feel safe,** as did the therapists setting manageable expectations but working towards a universal responsibility to speak. This responsibility served several functions including reducing uncertainty, allaying fears of being judged by silent group members and building group members' confidence through active participation.

Participants valued some of the boundaries set by the clinic as mentioned above. This seemed to protect against worries about other group members. Conversely participants valued the sometimes informal nature of the clinic's role. This **relaxed informal atmosphere** seemed to protect against worries about the clinic itself and the group content. Participants repeatedly praised a seeming lack of hierarchy, hospitality and informal conversation, a lack of rigid rules, especially around leaving the room, and the role of humour. For example, *"and even if I don't make it very well in the week I know that when I go to the group I've got that supportive atmosphere and that it doesn't feel like a hierarchy from [group therapist] to us."*

Participants moved from evaluating their safety based on past experiences and pre-existing attitudes, to direct experience of the group. All three participants who dropped out of a group cited feeling unsafe as their reason for doing so. This generally, but not exclusively, resulted from **negative experiences of mindfulness**, including practices triggering a sense of threat, flashbacks and voices, and feeling disconnected from the group while others meditated "happily". Some of the participants' who dropped out, reported that their sense of threat was intense and enduring: For example, *"I didn't sleep because I was worried about going (…) my anxiety was getting really bad and I was having flashbacks of all the things I didn't like from the week before."* Others felt the sense of threat was intractable: For example, *"I just imagined that would keep happening (…) I think it's just not for me really"* This can be contrasted with mild anxiety that resolves during a session. For example, *"I felt a bit self-conscious about doing it (…) but by the end of it I was able to sit and relax properly."* Or problems that felt solvable in collaboration with the clinic over time (see category F). One of the participants who dropped out, reported feeling ambivalent about doing so, and for that reason would have valued ongoing contact with the clinic as a means to reconnect. For example, *"Maybe I should have told her to call me back because maybe I would have gone back."* This participant reconnected with the clinic as a result of participation in this research.

Participants also reported a variety of **difficult interpersonal experiences in the group.** Some participants described a general tendency towards interpersonal anxiety, while others specified that the level of disclosure expected was too exposing. Some group members were distressed by the unusual views of another group member who they perceived as different from the group. Other participants felt different and misunderstood themselves:

> For me it's different because I'm always the odd one out. I feel like I'm the only mixed race one or I'm the only one that looks different from everyone else. I always feel like I'm the only one that speaks out, so it's quite hard sometimes when you've got to fit in to different groups.

The anxiety of feeling different was ameliorated by **discovering universality**. This often seemed to happen quickly. It was enhanced by the universal sense of purpose of the NHS location and by bringing voices into the open early. Participants felt this allowed them to then invest in the group by taking a risk and being open. For example, *"you feel part of the group and because they've all got the same thing, it helps you to talk. Get all your thoughts out that you've bottled up."*

Category C. Working

Participants described **learning** from facilitators and one another, particularly how to deal with voices without fearing them and how to understand them better. For example, *"they're helping you to understand that the voices can't harm you and you can resist what they're saying."* Participants described a number of challenges in **incorporating the therapy into life**. This involved making time for the group, developing strategies to prompt home practice and refining techniques through trial and error. For example,*"because I do it, I try it and if it don't work, well I'll move to something else."* Participants noted that different

physical environments (for example, quiet vs. noisy) and different emotional states (relaxed vs. agitated) were more or less conducive to applying the techniques successfully. Despite this, some participants planned mindfulness practices proactively, while others reacted when they felt it most necessary. For example, *"at night is a time when I'm panicking because that's the worst time and I'm flooding the room with lights and- so usually it's a panic stricken, 'oh my god I must do the mindfulness now'."*

Category D. Usefulness

Participants arrived with a variety of **aims for the voices,** including understanding them better, controlling them and getting rid of them completely. Participants also discussed **interpersonal aims**, including catharsis and sharing experiences with like-minded others. This seemed to be particularly driven by a lack of opportunity to discuss voices in routine services and the effects of stigma in silencing help-seeking from family and friends. For example, *"...just to be with other people that were experiencing the same thing, because it's not something you can just talk to anyone about really, is it?"* Participants also talked about their **hopes for their lives.** Participants spoke of voices driving self-harm, limiting one's horizons and affecting one's family. When discussing the impact of voices in this way, participants repeatedly talked about a *need* to change. This felt *need* to change resulted in a determination to maximise engagement as discussed later (see category F) and can be contrasted with **giving it a go**. For example, *"I just throw myself in (because…) I have to do this. I have to. Because if I don't do this I'm going to be like this the rest of my life and I want to do things with my life."*

Before beginning therapy, participants seemed to evaluate the potential usefulness of the group based on their aims (discussed above) and their **hopefulness in the clinic**. **Hopefulness in the clinic** was determined by participants' prior experiences of services, their

hopefulness in a group approach and their ability to accommodate a psychological model of voice hearing. For example, *"I think people might have this idea that psychological therapy (…) it's just peripheral to the main treatment, which is medication and monitoring. So (…) why would I do it?"* Positive experiences of level one of the clinic (four sessions of individual therapy before starting the group) seemed to engender hopefulness, but expectations of a group approach often had a countervailing effect. For example, *"From doing my one on one (…) because she was so good working with me, I thought (…) "oh the group's going to be really shit because it's not one on one."* Some participants showed **flexibility in evaluating** the usefulness of the group by suspending judgement at first (as discussed in category A) and adjusting their expectations over time. For example, *"at first I thought it would maybe get rid of it (the voices) altogether (…) but I've learnt that they can't get rid of it altogether but they help you to understand it."*

As participants began to engage with the therapy they were able to evaluate its usefulness based on the rewards of engagement. This included **useful learning,** such as searching for evidence to question voices, gaining autonomy over voices and mindfulness aiding relaxation. For example: "*sometimes when the voices tell me something I question them now. Because I think, "yea (therapist)'s right, he says "you need to have evidence""* Many participants also reaped **interpersonal rewards** from engaging in the therapy, including, universality/ shared suffering, feeling understood by others, finding one's contributions were respected, exchanging in compassionate interactions, catharsis, a cohesive attachment to the group and the self-esteem gained by inspiring others. For example, *"you want to communicate your ideas and hopefully be some kind of role model really"*

The extent to which these rewards motivated further investment in the therapy was determined by how much participants **expected, noticed and linked rewards to the therapy**. For example, *"I: (What) made you want to keep attending the group? (…)*

P: (…) Just knowing that the mindfulness was helping me and making a difference."

Sometimes participants noticed progress in the moment, but at other times the clinic purposefully drew participants' attention to their progress. One way the clinic managed this was by mapping the group journey. For example, *"They always have it on the wall. What we did the previous week. (…) So we all know, (…) "the voices are not true because we did go for a coffee or someone went swimming".* This quote demonstrates that the therapeutic task of finding evidence to question voices, dovetails with noticing progress. Many participants found this particularly motivating. For some, the rewards of engagement were pronounced, while others drew pride simply from attending the group, and drew hope from participating in a group journey and seeing others cope.

Category E. Barriers

Problems arising from a group approach per se or the therapy content, for example mindfulness, have been grouped under "evaluating", rather than barriers to engagement. The barriers grouped here are personal barriers, or external barriers not intrinsic to the therapeutic approach. For example participants faced cognitive barriers, unstable home lives, physical health problems, mood problems, interfering voices, problems with the clinic location, and technical problems with the mindfulness recordings. For example, *"either [I] didn't understand the question [therapist] was doing or I just- sorry I have bad memory as well, it's not helping."* These obstacles ranged from momentary and irritating, to enduring and debilitating. They affected the safety and usefulness of the therapy. For example:

I think to be honest he has a fairly bad drug problem. I think for him just organising himself to get to the group was quite difficult: finances, getting enough money together to get a bus and I think he just had a fairly chaotic lifestyle so that made it hard.

Managing difficulties and renewing commitment.

The strategies deployed to maintain the usefulness of the therapy in the face of these barriers *and* those arising from a group approach and the group content are described here. Some difficulties were predictable and had reliable solutions while others were idiosyncratic, arose unexpectedly and required tailored solutions. Problems were solved by individuals, facilitators, or through collaboration between people.

Participants **managed difference in the group** through: regulating their own behaviour to fit in, pairing with a like-minded other and showing compassion for people who were group outliers. Participants felt that the clinic modelled this compassionate approach but also that their underlying commonalities drove mutual respect. For example:

There's one of the ladies is very religious and (…) she can sometimes say quite strange things (…) I think we've learnt through the facilitator to care for her and respect she (…) may be a bit different but she's equal in her rights to have a voice.

Sometimes the clinic took on the job of regulating contributions from people who were outliers in the group, to the extent that one group member was asked to leave. *"And we felt that actually her presence in the group was too disruptive in terms of the flow (…) because she would just sit there stone faced (…) not engaging at all. (…) So we asked her to leave."*

Participants availed of **interpersonal support to apply learning** from friends and family, other services and other group members. They worried about this support ending when the group ended, as acknowledged by a group therapist: *"Ideally we would have a meeting with everyone's care-coordinator at the end of therapy (…) to ensure that learning is placed in multiple hands"* Participants seemed better able to tolerate difficult aspects of the

group when others shared those difficulties. For example, *"there were a couple of people who didn't really like mindfulness (…) So it felt much easier for me to say, 'yea I didn't really get on with it'"* This contrasts with another participant's experience, which was part of the reason she dropped out: *"I just felt really awkward because everyone else was doing what they were supposed to be doing and I wasn't."*

Where participants felt they had much to gain from therapy, they showed real **determination through adversity**. For example, *"I managed to go but it took me about four hours to get out of the house and go."* This quote captures this participant's determination to apply learning at home, but many participants also spoke of their determination to maximise group attendance and their disappointment at missing a session. Participants found it harder to go back after missing a session but this was helped by **staying connected with the group process**. This was achieved in a number of ways, for example by the clinic phoning group members between sessions. This meant participants felt held in mind and cared for but it also assuaged guilt about missing a session and allowed the clinic to support group members with individual problems. For example, *"I made it back the next week, because they ring you (…) So I told them what had happened (…) and now they manage her differently."* Some participants also valued being called after they dropped out. This allowed them to leave on good terms and consider reconnecting with the clinic in future.

Category G. Responses to ending.

All but one service-user participant described feeling worried about therapy coming to an end. Participants were worried about the **loss** of an outlet to discuss voices, a witness to their progress and a sense of group belonging. Many participants felt they might 'go downhill' after the group ended. For example, *"What about all I've done, going out and everything, making big steps. What am I going to do? If it stops (…) what if I go downhill?*

And what if I just go downhill? And I can't go downhill." However, three of the four participants interviewed after finishing or dropping out of a group, described integrating aspects of the therapy into their lives in various ways.

Participants described internalising positive aspects of the group experience long after the group had finished, including universality and the hopefulness of seeing others cope:

> I suppose I've still held on to the fact that there are people who suffer with voices but they can really get on with their lives and really deal with them. (…) So yea, that's been really positive.

Interestingly Sam dropped out of the group early and didn't report a particularly positive experience overall. The above quotes contrast with the perspective of two of the group therapists who felt these "common factor" effects would be short-lived. For example:

> The fact that you have the same experience as me is comforting in the moment but that's all well and good. When I go home I'm still hearing voices, I'm not going to think, 'oh Ciaran also hears voices, isn't that really comforting'.

Participants also **integrated** new learning about voices and mindfulness techniques into their lives to varying extents. Some participants continued to use the mindfulness recording and incorporated this into their routine, while others drew upon mindfulness in flexible and idiosyncratic ways. For example:

> It's not just one exercise but that there are lots of different ways you can practice mindfulness. It doesn't have to be something you have to listen to on an mp3 player.

Participants also varied in their aims in applying mindfulness, with some using it to endure difficult new situations and others using it to enhance pre-existing coping strategies, including avoiding activity. For example,

> In the afternoon it always seems worse. (…) And then I think, "I'm going to go to bed". So then I lie in bed and put the mindfulness thing on and I can feel it calm me down because it's quite relaxing.

Most participants felt that ongoing social support was necessary to apply the learning from therapy. However, some thought quite flexibly about who could provide this support (including community mindfulness groups) while others saw this as a dichotomy between supportive mental health services or self-sufficiency. For example, *"What if they ain't got anything else for me? And then I have to do it myself again?"* As discussed earlier this may be partly driven by stigma. "It's really tough because it's not like *you can advertise on Facebook. 'I'm starting a group'. It's all very secretive, it's all behind closed doors."* Most participants had never heard of the hearing voices network and only one considered that she could recruit ongoing support with mindfulness practices outside a mental health setting.

Discussion

This study is the first attempt to build a theory of engagement in mindfulness based group therapy for distressing voice hearing. This study also makes a unique contribution by incorporating the views of people who dropped out from group therapy into the analysis. The core category that emerged from the analysis was: "investing in changes that seem safe, manageable and useful". The study's findings will now be discussed in relation to established theory, clinical and research recommendations will be drawn out, and the study's limitations will be discussed.

Links with extant literature.

The model of engagement depicts a recursive process of investing in change and evaluating its usefulness and safety. This can be understood in terms of expectancy-motivation (Vroom, 1964). Participants' expectations about achieving their goals through therapy appeared to initially be informed by past experiences, and later by direct experience of the group, and these expectations seemed to drive their motivation. The sub-category "expecting rewards, noticing them and linking them to the therapy" captures this process. A previous grounded theory study also found that service users' prior experiences of mental health services for psychosis was a prominent factor contributing to their engagement with new mental health teams and treatment options (Stewart, 2013).

Participants' hopefulness in the clinic before therapy was also influenced by their perception of the compatibility between the clinic approach and their personal aims. This fits with studies that suggest agreement on the goals and tasks of therapy is a necessary condition for group cohesion (Bernard & Drob, 1989; Marziali, Munroe-Bum & McCleary, 1997). Cohesion (Yalom & Leszcz, 2005) emerged as an "interpersonal reward" in the present study. Participants in this study may have gained a cohering sense of collaborating on shared tasks through the "group journey" being mapped on the wall week by week. Embarking on a group journey also emerged as a higher order category in a recent grounded theory method study of mindfulness based groups (Cormack, Jones & Maltby, 2018).

Participants faced several threats to their perceived safety in the groups. Several reported worrying that they would be seen as "crazy" or that others would be "too ill". This could be seen as internalised stigma about mental health problems, which has been found to interfere with help-seeking (Clement et al., 2015). Indeed many participants found it cathartic

to finally discuss voices in depth, since they felt unable to do so with others in their lives due to perceived stigma.

A few participants described distressing experiences arising from mindfulness practices. In some cases this compromised participants' sense of safety, leading to drop out. Previous research has found that meditating with others as part of a group mindfulness based intervention can foster group solidarity, connectedness and a sense of safety (Cormack, Jones & Maltby, 2018). A systematic review of mindfulness based interventions for distressing voice hearing found that participants viewed mindfulness practices as safe and acceptable as part of therapy, including in a group format (Strauss, Thomas & Hayward, 2015). However in the Strauss, Thomas and Hayward (2015), as in the present study, a minority of participants were distressed by mindfulness practices. Participants in the present study attributed difficulties with mindfulness practices to trust issues and reliving experiences arising from previous trauma.

Many participants acknowledged that they were reluctant to speak in their group at first due to some of the interpersonal concerns already discussed. Most people overcame this by recognising that others shared similar experiences of voice hearing. Participants cited perceived universality (Yalom & Leszcz, 2005) as a facilitator of, and an enduring reward of engagement even long after groups had ended. This fits with recent research, which found that developing a normalised account of voice-hearing and the witnessing of preferred narratives by others were essential in developing a more robust "turning toward" recovery typology (deJager et al., 2016).

Other participants reported that they were able to speak for the first time in the group because their group therapist elicited contributions from everyone at particular times in each session. They perceived that there was a universal responsibility to speak and this norm

helped them to take a risk and self-disclose. This fits with Bednar, Melnick & Kaul's (1974) risk, responsibility and structure model. This model posits that group structure reduces ambiguity, and thus anticipatory anxiety, and facilitates greater participation and risk-taking from members. "Reducing uncertainty" emerged as a sub-category in the present study. Many participants also noted that the familiar session structure and written group agreement reduced their uncertainty and facilitated their participation. The group therapist systematically eliciting contributions from everyone may be useful in another way. Research has shown that group leaders can sometimes let quieter group members withdraw from discussions and these participants are at particular risk of dropping out (Stwine, 1994). This may be due to a self-fulfilling prophecy: group leaders have less therapeutic optimism about particular clients, who then confirm leaders' expectations by dropping out, the so-called "Golem effect" (Babad, Inbar & Rosenthal, 1982). Systematically eliciting contributions from all group members may guard against this.

Some participants reported finding it particularly difficult to go back after missing a session. These participants found that phone calls made by the clinic between sessions helped them return to the group. Beyond this, seven from ten service-user participants made positive mention of the clinic phone calls. This fits with findings that between session praise and encouragement improves attendance at group therapy (Blake, Owens & Kane, 1990) and that this may have particular benefits for service-users who have missed some sessions (Delsignore, et al., 2016).

Clinical recommendations

As just discussed, participants valued structures that reduced ambiguity, and thus ameliorated their anxiety. Given this, a leaflet has been produced in the clinic in the present study and distributed to service-users prior to their beginning group therapy. This is aimed at

reducing uncertainty and instilling a sense of universality and hopefulness in the clinic approach –factors that were found to facilitate early engagement in the present study. The findings presented here suggest such an intervention may facilitate engagement, though this should be tested empirically.

As discussed earlier, some participants, for various reasons, felt unsafe meditating as part of group therapy. Group therapists should be alert to the risk of mindfulness practices causing distress and should collaborate with group members in developing a response. For example, one of our participants continued to participate in the group and valued the CBT elements, but chose not to take part in mindfulness practices. Two other participants chose to leave the group and were offered another therapy modality. Our findings suggest that sharing difficult experiences of mindfulness practices in the group allowed some participants to persist with practices and eventually benefit, and allowed others to opt out and seek alternative treatment options as described above. Therefore encouraging group members to openly share difficulties with mindfulness practices seems to be important.

The participants who dropped out of a group all valued that they were actively followed up by the clinic. In two instances they chose to take up individual therapy instead, and a third participant chose to reconnect with the clinic after taking part in this research. These participants are a self-selecting sample since they all agreed to participate in the research. However, these findings suggest that proactively following up those who drop out of groups and attempting to facilitate a positive experience of leaving the group is important. This fits with previous research that found that people who drop out later in group therapy can have worse outcomes than those who drop out early, perhaps because of the emotional impact of leaving an established group or perhaps because they were not offered other sources of help (Stiwne, 1994).

The participants who were interviewed several months after finishing therapy reported that they had integrated aspects of the therapy into their lives. However, they felt that ongoing social support would have helped them better maintain gains from therapy. This might be achieved through passing this role on to care co-ordinators, signposting group members to the hearing voices network and community mindfulness groups, or facilitating a "group graduates" group that would meet on an ongoing basis.

Limitations and research recommendations

This study sacrificed breadth of explanatory power for depth of understanding of a particular phenomenon. The study recruited a small sample from one clinic in an urban location in the south of England. Therefore, we must be cautious in generalising the findings to other mindfulness groups or group therapies for distressing voices. Future qualitative and quantitative work is required to test the validity of this model of engagement with other samples. A future grounded theory method study could theoretically sample from a broad range of groups to discover the engagement processes that seem to generalise across therapy modalities difficulties and target difficulties.

Finally, it's possible that new codes relating to dropout would have emerged if more participants were recruited who had dropped out from groups However, this is an important step forward since very few studies have elicited the views of those who have dropped out from group therapy in past research. Future research might theoretically sample more from this population to densify categories relating to dropout.

Conclusions

The model that emerged from this grounded theory method study theorises a recursive process where group members continuously invest in change as they evaluate its usefulness and safety. Safety and usefulness are initially evaluated based on past experiences and

attitudes to the clinic approach and later through direct experience of the group. If safety is perceived to be compromised this may precipitate dropout. However, group member anxiety can be ameliorated through group structures that reduce uncertainty, encourage contributions from all members and establish universality around voice hearing early. Contact between sessions can help group members stay connected with the group process, feel cared for by the service and problem solve difficulties in collaboration with the service. Mapping the group's progress over the weeks may assist in challenging voice content and engendering a cohering sense of collaboration on shared therapeutic tasks. Normalising and validating difficulties with group content such as mindfulness can allow group members to persist in the face of these difficulties. Therapists should be alert to difficulties with mindfulness practices and offer alternative treatment options if necessary. Therapeutic effects seem to come from group content, for example finding evidence to question voices and learning mindfulness techniques; and interpersonal processes such as universality, cohesion, social learning and drawing hope from others coping. Both sorts of therapeutic effect can be internalised well beyond group termination. However, some are lost and the social support to maintain progress may be lacking, partly due to stigma blocking support seeking. The study is limited by recruiting a small number of clients who dropped out from therapy.

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Table 1.

Categories and Sub-Categories of a Model of Engagement in Group PBCT.

Categories	Sub-categories
A. Giving it a go	1. Giving it a go
B. Safety	2. Worries about starting the therapy
	3. Making the context feel safe
	4. Reducing uncertainty
	5. Making the work feel safe
	6. Relaxed informal atmosphere
	7. Negative experiences of mindfulness
	8. Difficult interpersonal experiences
	9. Discovering universality
C. Working	10. Learning
	11. Incorporating the therapy into life
D. Usefulness	12. Aims for voices
	13. Interpersonal aims
	14. Hopes for life
	15. Hopefulness in the clinic
	16. Flexibility of evaluation
	17. Useful learning
	18. Interpersonal rewards

	19. Expecting rewards, noticing them and linking them to the therapy
E. Barriers	20. Barriers
F. Managing difficulties and renewing commitment	21. Managing difference in the group
	22. Interpersonal support to apply learning
	23. Determination through adversity
	24. Staying connected with the group process
G. Responses to ending	25. Integration
	26. Loss