

THE UNIVERSITY OF HULL

Disclosure of Voice Hearing and Mental Health Problems: Experiences and
Effects

being a Thesis submitted in partial fulfilment
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Overview

Research suggests that people who experience mental health problems and people who hear voices are likely to experience stigmatising attitudes and discrimination. This portfolio considers the experiences and impact of disclosing these stigmatised experiences, both to immediate family, friends, and partners, and to people in wider society. The portfolio has three parts.

Part one is a systematic literature review which considers the impact/effect of disclosing mental health problems by reviewing the literature base. Twelve articles which aimed to answer the research question were quality assessed, then compared and contrasted in order to provide conclusions and offer recommendations for future research and clinical practice.

Part two is an empirical study which enquires into the personal experiences of people who hear voices using Interpretative Phenomenological Analysis (IPA). Six participants were interviewed about their experiences of talking about hearing voices with family, friends, and other people they considered close to them. Themes were developed from the interviews and conclusions were drawn about future research and clinical implications.

Part three of this portfolio contains the appendices, consisting of supporting documents from the literature review and empirical study, along with both epistemological and reflective statements.

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Part One: Systematic literature review

This paper is written in the format ready for submission to the journal

Clinical Psychology Review

Please see Appendix A for the submission guidelines

The Effects of Disclosing Mental Health Difficulties: A Systematic Literature Review

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Abstract

Mental health problems are reported to affect a quarter of the UK population. Despite this, people with mental health problems still face widespread stigma and discrimination, leaving them fearing the consequences of disclosing their experiences. The purpose of this systematic literature review was to consider the impact/effect of disclosing mental health difficulties. Twelve articles were quality assessed, then compared and contrasted in a narrative synthesis. Tentative conclusions were drawn, recognising that disclosing mental health difficulties could impact upon how the discloser is viewed and treated by others, upon the discloser's mental health, and upon the individuals disclosed to. Two further variables appeared to influence these effects: who is disclosed to and the process of disclosure. Variability in the available literature was explored and recommendations for future research and clinical practice were suggested.

Keywords

Disclosure, mental health, mental illness, review

Highlights

- Mental health difficulties are not purely individual problems
- Disclosing mental health problems can lead to complex outcomes
- Disclosing can affect mental health and other's judgements
- The effects of disclosure are mediated by who is disclosed to and how

Introduction

It is frequently quoted that one in four people in the UK will experience mental health problems across the life span (World Health Organisation, 2001). Many difficulties are held under the banner of “mental health problems” or “mental illness”; including those involving low or highly variable mood, anxiety, hearing things that others do not, holding beliefs that many in society consider unusual, and eating problems. Many approaches have been used to understand why some people face difficulties referred to here as mental health problems and why other people do not. Perhaps the most well-known approach to understanding mental health problems is the biomedical model, where difficulties and distress are understood as a biological problem, analogous to physical disease (World Health Organisation, 1992). Diagnostic labels such as Schizophrenia, Bipolar Disorder, and Major Depressive Disorder are associated with the biomedical explanatory model, and aim to categorise patterns of feelings, thoughts, and behaviours that appear to frequently occur together (American Psychiatric Association, 2013; World Health Organisation, 1992).

The biomedical model of mental health has greatly furthered our understanding of people’s difficulties and provided methods of “treatment”, such as medications, which can help to reduce the associated distress of the individual. Despite this, the biomedical approach can be critiqued for multiple reasons: the diagnostic categories are frequently limited in terms of validity and reliability, the emphasis on biological processes minimises the effects of social and psychological factors, the approach undermines individuals’ capacities to understand their own experiences in their own way, and perhaps most importantly for the present review, the model decontextualizes experiences, suggesting a problem lies within an individual, rather than being a product of their experience and environment (British Psychological Society, 2013). There is evidence that indicates, whether mental health difficulties are medically caused or not, a

person's social environment can have a major impact on their mental health. Individuals rarely exist in isolation, but instead exist within a wide network, involving family, friends, occupations, local communities, wider social discourses, and political contexts. It is therefore essential to consider the impact of individuals' social, cultural, and political environments when attempting to understand their mental health (Fiori & Jager, 2012; Pharr, Moonie, & Bungum, 2012; Richards & Paskov, 2016; Rickwood, Mazzer, & Telford, 2015; World Health Organisation, 2014).

An example of the impact of others on individuals with mental health difficulties is the stigma associated with mental health. Stigma refers to when an individual is negatively stereotyped, treated differently, labelled, or faces prejudice and discrimination because of their experiences. Stigmatising views can be held about other people, about oneself in the form of self-stigma, or in discourses throughout wider society (Clement, et al., 2014; Ma, 2017). In a study which examined the experiences of stigma and discrimination in individuals involved with mental health services, participants reported experiencing stigma from multiple sources, including their communities, families, churches, co-workers, and mental health caregivers. The majority of participants reported that they attempted to conceal their mental health difficulties for fear of negative treatment from others. Furthermore, participants described discouragement, hurt, anger, and low self-esteem as a result of their experiences (Wahl, 1999). A literature review of 144 studies with 90,189 participants considered the impact of mental health stigma on help-seeking. The review reported that higher levels of stigma were negatively associated with help-seeking, where high internalised stigma and treatment stigma were most related to low help-seeking. Similar to the conclusions of Wahl (1999), this review reported that disclosure concerns were one of the largest stigma barriers (Clement, et al., 2014).

Another review considered how mental health is portrayed in the media in order to understand mental health stigma. The review suggested that despite some advertisements and social media becoming more informative about mental health difficulties over time, the media generally still portrays mental health problems negatively, which contributes to ongoing mental health stigmatisation (Ma, 2017). It is clear that people with mental health difficulties are likely to experience stigma and that this can have a negative impact on their emotions, self-esteem, and likeliness of seeking support. One review also considered the economic impact of mental health stigma. The review found that mental health stigma and discrimination can impact negatively on employment, income, public views about how resources should be allocated, and the overall costs of healthcare. It was therefore recommended that interventions which reduce stigma would likely be economically beneficial (Sharac, McCrone, Clement, & Thornicroft, 2010).

Given the stigma associated with mental health difficulties and the associated hesitance to disclose, it is important to consider what happens when people do disclose mental health problems or a psychiatric diagnosis. Corrigan and Matthews (2003) considered whether the experiences of the gay, lesbian, and bisexual (LGB) community may provide insight into the impact of disclosing mental health problems. They proposed that the analogy could be useful because, unlike other groups which may be stigmatised based on physical attributes (e.g. skin colour, physical disability, age), sexuality and mental health status can rarely be easily observed, so that an individual to some extent has choice whether to declare this information. They also made other comparisons such as the non-binary nature of mental health (not simply mentally ill or mentally well) and sexuality (not just straight or gay), that sexuality and mental health status are rarely known at birth but often come to develop/be known in adolescence, and perhaps most importantly, both groups are known to face stigma due to society wide

misperceptions. With this analogy in mind, Corrigan and Matthews (2003) suggested that there may be benefits to disclosing mental health problems, including improved psychological wellbeing through increased self-esteem and decreased distress, diminished risky behaviours, improved interpersonal relationships, and enhanced relatedness to key institutions such as work. However, they also suggested potential costs, including physical harm from others, social avoidance and disapproval from others, self-consciousness, and self-fulfilling prophecies. Corrigan and Matthews (2003) overall suggest that there may be both positive and negative outcomes of disclosing mental health difficulties.

It is important to highlight that, although there might be some similarities between disclosing mental health difficulties and disclosing LGB status, there are important distinctions between the two groups. Firstly, a primary feature of mental health problems is the idea that they should be treated with therapeutic support, whereas the vast majority of mental health practitioners recognise LGB status as an alternative sexuality and not a target for treatment. Similarly, individuals with LGB status are appropriately encouraged to accept their sexuality, whereas this is rarely encouraged for mental health difficulties (Corrigan & Matthews, 2003). However, the analogy might provide potential areas to consider when exploring the effects of disclosing mental health difficulties.

Research Aims and Question

It is well recognised that stigma can have a negative impact on individuals with mental health problems. It is also recognised that “coming out” about other stigmatised experiences can be a complex experience which can have both positive and negative outcomes for people’s lives. The purpose of this systematic literature review was

therefore to evaluate the impact of disclosing mental health difficulties; whether this is to family, friends, employers, or any other people.

Disclosure can be defined as “The action of making new or secret information known” (Oxford University Press, 2018) and involves both a person disclosing and a person (or multiple people) disclosed to. The term “disclosure” could have multiple meanings when considering what is meant by “disclosure of mental health difficulties”. For example, it could refer to disclosing certain thoughts (e.g. “I keep thinking I’m going to become ill whenever I’m out of the house”), disclosing emotional states (“I’ve been feeling really upset for a long time”), disclosing changes in behaviour (“I’ve been hiding away from the world”), disclosing a psychiatric diagnosis (“I have a diagnosis of schizophrenia”), or disclosing difficulties in a more colloquial way (“I think I’m losing my mind”). A particular problem with defining “disclosure of mental health problems” as disclosure of certain thoughts, emotions, or behaviours is that it is not clear whether the person disclosed to views the individual to be experiencing a mental health problem or attributes the experiences to a different cause. For the purpose of this review “disclosure of mental health problems” therefore refers to disclosure of a psychiatric diagnosis (e.g. “schizophrenia”, “bipolar disorder”, or “ADHD”) or a term/label understood to refer to a mental health difficulty (e.g. mental illness, psychosis, depressed). The research question was:

What is the impact/effect of disclosing mental health difficulties?

Methods

Search Strategy

An initial search was undertaken in order to assess whether the research question had already been sufficiently answered by previous literature reviews. A total of seven related literature reviews were found, however these reviews did not fully answer the

specific research question. Two specifically examined disclosure to the workplace, two examined reasons and attitudes towards seeking mental health support, one examined tools to support disclosure, one reported on research around supporting people with serious mental illness into work, and one examined the impact of interviewers' disclosing their own mental health difficulties (Brohan, et al., 2012; Hamilton, et al., 2011; Hielscher & Waghorn, 2015; Jones, 2011; Mueser & McGurk, 2014; Nam, et al., 2013; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Though previous reviews found valuable insights into specific areas, such as the frequency of disclosures, how to support disclosures, or why people may disclose, they did not specifically address the impact or effect of the disclosures more generally. The present review could therefore offer insight into how people might respond to disclosures, whether disclosing has any impact on wellbeing, and if anything else changes for the disclosing individuals. This information could then go on to help people with mental health difficulties be more aware of the potential outcomes of disclosing, supporting people who may wish to disclose.

The following databases were chosen in order to find journal articles relevant to the research question: Academic Search Premier, CINAHL Complete, MEDLINE, and PsycINFO. The rationale for using these databases was to include those which contain articles from many research disciplines alongside psychology specific databases.

Search terms and search limits

After articles in the research area were read and examined, the following search terms were selected:

("coming out" OR disclose OR disclosure OR disclosing) N5 ("mental* ill*" OR "mental health" OR "mental disorder*" OR "psychological* ill*" OR "psychological disorder*" OR "psychological problem*" OR "psychiatric

disorder*” OR “psychiatric problem*” OR “psychiatric illness*” OR
“psychiatric disabilit*” OR “psychological disabilit*” OR anxi* OR depress*
OR psychosis OR psychotic OR schizophreni* OR schizoaffective OR
“personality disorder*” OR bipolar OR neurosis OR “eating disorder*” OR
“attention deficit hyperactivity disorder*” OR “attention deficit disorder*” OR
ADHD OR OCD OR “obsessive compulsive disorder*” OR PTSD OR “post
trauma* stress” OR “seasonal affective disorder” OR manic OR hypomani* OR
mania OR “panic disorder*” OR phobia* OR “dissociative amnesia” OR
“dissociative fugue” OR “dissociative identit*” OR “dissociative disorder*” OR
anorex* or bulimi* OR pica OR “binge eating disorder”) NOT HIV

The search was limited to peer reviewed articles. The search term “OR” was used as there were many different terms which could potentially be used to replace the words “disclosure” and “mental health problem”. Common psychiatric diagnoses from the most widely used diagnostic manuals, the ICD-10 and DSM-5, were included in the search to ensure that as many relevant papers, which might use different terminology, were included (World Health Organisation, 2001; American Psychiatric Association, 2013). The search term “N5” (meaning “within 5 words distance”) was used to search for papers where the terms associated with disclosure (e.g. disclose or “coming out”) and the terms associated with mental health problems (e.g. mental health problem, mental illness, or psychiatric disorder) were close together in the articles; in either the title, abstract, or full body of text. This was deemed necessary as the term “AND” was finding many irrelevant papers. “N5” was chosen rather than “N4” or lower as all relevant papers previously found were kept with “N5” but not with a lower distance between the terms. The search character “*” was used to ensure that words which can have multiple endings were found. For example “anxi*” could be used to find the terms

“anxiety”, “anxious”, and “anxieties”. Finally the search term “NOT” was chosen as many articles relating to HIV were found that were irrelevant to the research question and would unnecessarily increase the time it would take to find relevant articles.

Inclusion and Exclusion Criteria

The following inclusion and exclusion criteria were chosen in order to ensure that the articles selected were relevant to the research question.

Inclusion:

Criteria	Rationale
Peer reviewed journal articles only	To ensure that only articles of sufficient quality were reviewed
Must examine the impact or effect of disclosing mental health problems/mental illness	To ensure that only articles which relate to mental health disclosure, not other types of disclosure, are included.
Can relate to the impact on the discloser, people/person disclosed to, friends, family, occupation, etc.	To assess the range of effects disclosure can have on different people and circumstances
Can include direct disclosure by the individual or indirect disclosure by another person (e.g. family member)	In order to capture information about the influence of different types of disclosure
Articles must examine disclosure of adult mental health, not that of children	To ensure greater homogeneity in the articles selected.

Exclusion:

Criteria	Rationale
Research on disclosing other experiences (e.g. sexuality, health, etc.)	To ensure that only articles examining mental health disclosure are considered
Research around disclosure of mental illness to the client/patient	To ensure that the articles are assessing disclosure by, not to, the individual
Research around disclosing experiences (e.g. abuse, trauma, emotion, etc.)	To ensure that the focus of the review is on mental health/illness

Article Selection Summary

The initial literature search was undertaken on 17/10/16 and found 1794 articles. After duplicates were removed 1224 articles remained. The titles of these articles were read and all articles that were clearly unrelated to the research question, and inclusion/exclusion criteria, were removed. The review of article titles left 251 further articles, the abstracts of which were then read. Of these articles, 67 appeared potentially relevant to the research question. The remaining 67 articles were then read in full, leaving the final 12 articles which met all the inclusion criteria and none of the exclusion criteria. The reference lists of the remaining 12 articles were then read in order to discover any potentially missed articles. No further articles were found. The literature search, with the aforementioned search terms, was re-run up until February 2017 in order to establish whether any relevant articles had been published since the initial search. Again, no further articles were found. This process is represented by a PRISMA Diagram (Moher, Liberati, Tetzlaff, & Altman, 2009) in Figure 1:

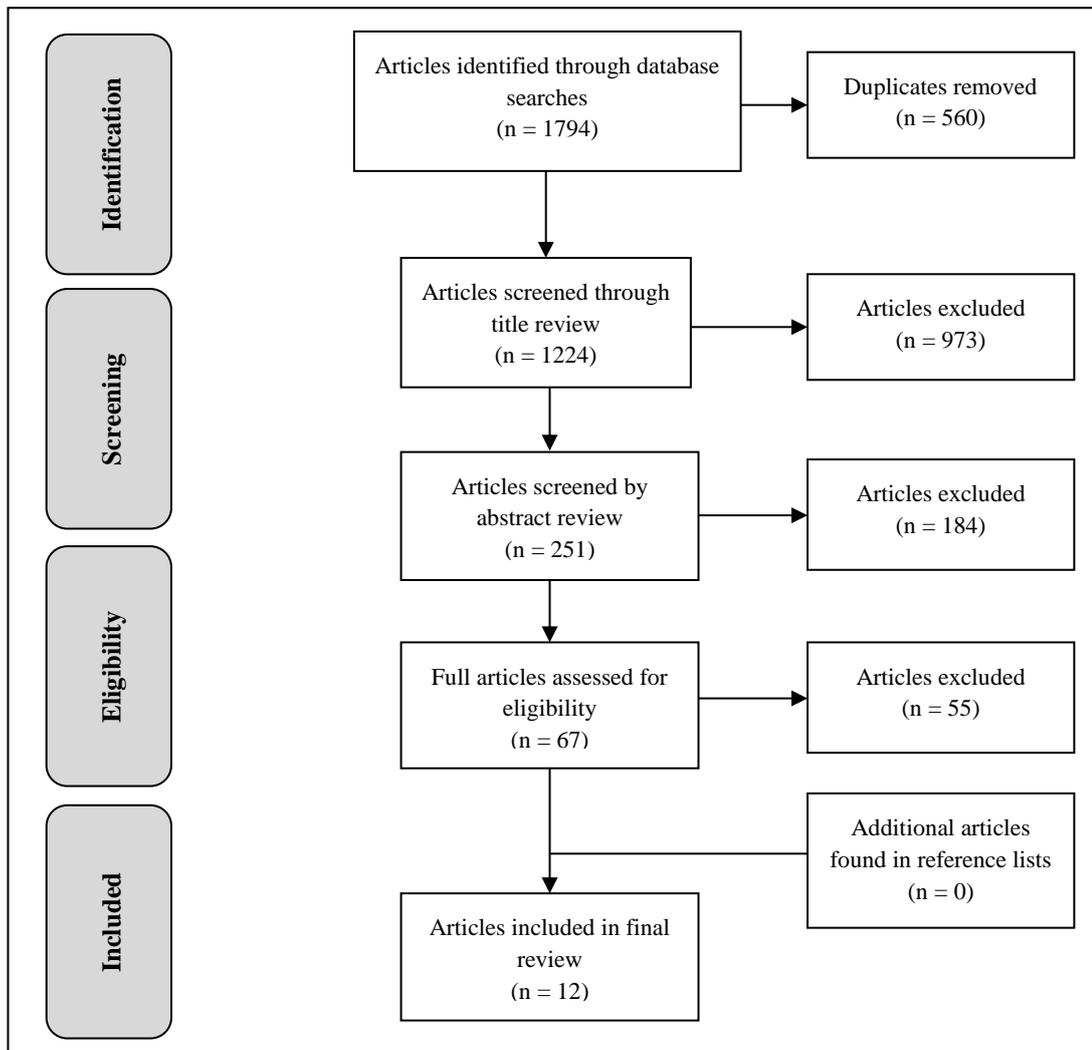


Figure 1: PRISMA Diagram (Moher, et al., 2009) representing the process of gathering the included research articles

Quality Review

As both qualitative and quantitative studies were included in the review, it was necessary to ensure that the quality of articles was assessed in accordance with their methodological and theoretical backgrounds. Separate qualitative and quantitative quality checklists were therefore used. The NICE quality checklists (NICE, 2012) were selected for this purpose, where both qualitative and quantitative checklists were available. As well as including many relevant areas of quality, the NICE checklists also offer a unique system for examining how the quality of articles might impact upon the literature review as a whole. Rather than giving a percentage or other numerical value,

the NICE checklists use “++”, “+”, and “-” to indicate whether an article greatly contributes high quality findings (++), contributes but is of less high quality (+), or detracts from the quality of the review (-). The Mixed Methods Appraisal Tool (MMAT; Pluye, et al., 2011) was also used. The MMAT is a simple tool used to assess the quality of articles of different methodologies. This therefore allowed some level of comparison between the qualitative and quantitative articles. In order to assess the inter-rater reliability of the MMAT and NICE checklist ratings, a percentage of the articles (36%, 3 quantitative and 2 qualitative) were reviewed by a peer. Any disagreements in ratings were discussed and the final ratings were agreed.

Data Analysis

As outlined in the PRISMA diagram (Moher, et al., 2009), only twelve papers were found which met the research criteria. Of these papers, large variance was found in methodologies; including a mix of qualitative and quantitative literature, variation in measures used, and diverse research questions (see Table 1). In order to make sense of the research available a method which could incorporate large variations in research methodology was necessary. Narrative synthesis is an approach which primarily uses words and text to convey findings from a group of research articles. However, as opposed to simply describing the findings of several articles relating to a research question, a narrative synthesis employs a systematic and rigorous approach to finding, reviewing, and quality assessing research articles. Furthermore, unlike other approaches which aim to review the evidence pertaining to a single intervention, a specific cause/effect relationship, or a narrower research question, narrative synthesis permits a wide-ranging approach which can examine a variety of methods, questions, and approaches pertaining to a research question (Cochrane Consumers and Communication Review Group, 2013; Popay, et al., 2006).

The narrative synthesis followed the following procedure, adapted from guidance by Cochrane and Lancaster University (Cochrane Consumers and Communication Review Group, 2013; Popay, et al., 2006). Following article selection each article was read through in depth. Relevant data was gathered from the articles to produce the data extraction table (see Table 1). The articles were then individually assessed for their methodological quality in order to give some indication as to the quality and trustworthiness of the findings. The articles were compared and contrasted in terms of their research methodology, quality, and their findings relevant to the research questions. Major similarities and differences were highlighted to develop an overview of the research articles' findings. The research findings were finally categorised under appropriate headings and written up as the research results.

Results

Overview of Literature

The primary characteristics and findings of the 12 included articles are shown in Table 1. A large amount of variability was found in the literature examined. Six articles looked broadly at mental health, three at depression, two at psychosis (including First Episode Psychosis, Schizophrenia, and other diagnoses), and one article at Attention Deficit/Hyperactivity Disorder (ADHD). Nine articles used quantitative methods (including experiments, correlations, and surveys) and three articles used qualitative methods (including content analysis, phenomenology, and thematic analysis). The majority of the research took place in the USA (8 articles), followed by Europe (3 articles; 1 from the UK, 1 from Germany, and 1 from the Netherlands), and finally Australia (1 article). Seven of the articles used individuals with diagnosed or self-reported mental health difficulties and five used participants from the general population or from student populations. Most of the research was relatively modern,

taking place in the 2010s (9 articles) or 2000s (2 articles), with the oldest article from the late 80s (1 article).

Table 1: Overview of research articles included in the review

Quantitative						
Author(s), Year, & Country	Aim(s)/Hypothesis(es)	Methodology	Measures Used	Participants	Mental Health Problem(s)	Overview of findings
Gurtman (1987). USA	To assess whether depressive disclosure led to negative evaluation from others.	Quantitative, experimental	7 point likert scale questions of rejection, adjustment, role impairment, and devaluation	90 Psychology College Students	Depression	Findings suggested that “depressive disclosures”, and sad or flat emotional displays, led to devaluation; in terms of rejection, devaluation, and discounting of the disclosing individual.
Jastrowski, Berlin, Sato, & Davies (2007). USA	The overall purpose of the study was to explore the effects of preventative disclosure of ADHD on young adults’ perceptions of a hypothetical peer exhibiting ADHD symptoms.	Quantitative, questionnaire	16 self-developed questions about a person’s character	306 Young adults, 67% Current Students	ADHD	Suggested preventative disclosure reduced socially rejecting attitudes, disclosure increased views that treatment would be helpful, and people felt treatment was more necessary for impulsive (rather than inattentive) symptoms.
Bos, Kanner, Muris, Janssen, & Mayer (2009). Netherlands	Investigated disclosure patterns among mental health consumers and examined the relationships among disclosure, perceived stigmatisation, perceived social support, and self-esteem	Quantitative, survey	Self-developed scale used to measure self-disclosure, Consumer Experience of Stigma Questionnaire (Wahl, 1999), Social Support List Interactions (Van Ejik, et al., 1994), Rosenberg’s Self Esteem Scale (Rosenberg, 1965)	500 mental health consumers	Schizophrenia or another psychotic disorder (24.2%), anxiety disorder (16.8%), depressive disorder (15.6%), bipolar disorder (15.4%), personality disorder (9.4%) or another mental disorder (15.2%). Diagnosis of 3.4% of the respondents unknown.	The research suggested that selective disclosure is best for social support and limits stigma. Perceived stigma negatively affected self-esteem. Self-disclosure interacted with other variables: perceived stigmatization, perceived social support, and self-esteem.

Author(s), Year, & Country	Aim(s)/Hypothesis(es)	Methodology	Measures Used	Participants	Mental Health Problem(s)	Overview of findings
Pandya, Bresee, Duckworth, Gay, & Fitzpatrick (2011). USA	Examined whom people with schizophrenia disclose their diagnosis to, whether they experience positive, negative, or neutral reactions to such disclosures, and what the consequences of disclosing were.	Quantitative, survey	Survey questionnaire containing rating scales about openness, treatment following disclosure, and reports of who disclosed to.	258 people with self-reported diagnosis	Schizophrenia or schizoaffective disorder	Participants were more likely to disclose to doctors, friends, and parents than employers and police. Those with better mental health or fewer relationships were more open. Worse treatment from police after disclosure and better treatment from parents. Worse treatment for medical problems after disclosure.
Scott, Caughlin, Donovan-Kicken, & Mikucki-Enyart (2013). USA	Study 1: The primary objective of the first study was to assess how different ways of disclosing depression might meaningfully influence the way others respond.	Quantitative, experimental	Text responses to a single question ranked in terms of "sophistication". No measures used.	504 Students at a large mid-western university	Depression	The results of the first study suggested that the way in which depression was disclosed affected how participants responded. In the second study responses which were less emotional, but instead provided compassionate responses, or helped the person understand their experiences differently were viewed as more supportive.
	Study 2: The objective of the second study was to explore how responses to depression disclosure with different message design logics are evaluated in terms of perceived quality or competence		Measures of message supportiveness (based on Goldsmith, et al., 2000) and message appropriateness (based on Caughlin, et al., 2008). Role Category Questionnaire (Crocket, 1965)	352 people diagnosed with depression	Major depressive disorder (45.17%), depressive disorder NOS (20.74%), major depressive episode (18.75%), bipolar disorder (11.93%), dysthymic disorder (3.13%), or cyclothymic disorder (.28%).	

Author(s), Year, & Country	Aim(s)/Hypothesis(es)	Methodology	Measures Used	Participants	Mental Health Problem(s)	Overview of findings
Burke, Wang, & Dovidio (2014). USA	Investigated how gender and attachment avoidance moderate the responses of third-party observers to information concerning depression disclosure decisions	Quantitative, survey	101 point scale used to measure "general feelings" about discloser. Self – developed measures of warmth and competence.	150 US adults	Depression	Participants generally liked the person more if they disclosed. In the first study men did not view the discloser more positively for disclosing depression, but did for other "stigmatised conditions". Women always preferred disclosure. Women and men low in attachment avoidance were positive about disclosure; men high in this variable were negative.
			Experiences in Close Relationship Scale—Short Form (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007) AND same measures as study 1.	301 US adults		
Mendel, Kissling, Reichhart, Bühner, & Hamann (2015). Germany	To study whether employees who disclose a psychiatric diagnosis, such as depression, risk stigmatisation and discrimination at the workplace.	Quantitative, experimental	Self-developed measure of views of discloser using 8 questions with a 5-point likert scale.	748 Managers	Depression (Psychiatric Diseases)	Identical complaints shown with different diagnoses (e.g. mental health or thyroid problems). Managers' attitudes and stigma were assessed. Depression and "burnout" more stigmatised than physical illness.

Author(s), Year, & Country	Aim(s)/Hypothesis(es)	Methodology	Measures Used	Participants	Mental Health Problem(s)	Overview of findings
Corrigan, et al. (2016). USA	Sought to examine people's understanding of the benefits of being out (BBOs) about mental illness, versus reasons for staying in (RSIs).	Quantitative, correlational	Self-developed Coming Out With Mental Illness Scale (COMIS). Questions of Professional Care Seeking and Extraprofessional Care Seeking. Self-stigma of Mental Illness Scale (SSMIS; Corrigan, et al., 2006), Brief Implicit Association Test for Self-Stigma (BIAT-SS; Greenwald, et al., 2009), Beck Cognitive Insight Scale (BCIS; Beck, et al., 2004), Basic Psychological Needs Scale (BPNS; Deci & Ryan, 2000), Attitudes Towards Psychiatric Medication (ATPM; Croghan, et al., 2003), Centre for Epidemiological Studies Depression Scale (CESD; Eaton, et al., 2004).	106 people with severe mental illness	Major depressive disorder (58.3%), bipolar disorder (41.7%), PTSD (31.1%), alcohol abuse or dependence (28.2%), other substance use or dependence (24.2%), psychotic disorder (35%).	Correlations for people out: BBOs not associated with implicit self-stigma. BBOs associated with self-reflexivity and associated with knowledge of and agreement with stigma (but not applying to self). BBOs associated with lifetime diagnosis of MDD. RSIs associated with high self-stigma, self-reflexivity, and bipolar diagnosis. These variables were also predictors of BBOs and RSIs. Correlations for people in: BBOs were associated with implicit self-stigma and negatively associated with a psychosis diagnosis. Impact for people out: BBOs not associated with basic psychological needs, negative relationship between autonomy and RSIs. BBOs associated with viewing medication as personally effective, seeking care (professional and extraprofessional). Coming out did not appear to affect depression. Impact for people in: BBOs associated with autonomy and relatedness, and inversely correlated with basic psychological needs.

Qualitative

Author(s), Year, & Country	Aim(s)/Hypothesis/ Hypotheses	Methodology	Participants	Mental Health Problem(s)	Overview of findings
Martin (2010). Australia	The purpose of this exploratory project was to generate knowledge about a relatively under-researched topic: the mental health of university students	Qualitative	54 students with self-reported mental illness	Depression (n = 35) and anxiety (n = 23). Anxiety included eating disorders. Two students were recorded for both schizophrenia and bi-polar affective disorder. Individual students reported: post-traumatic stress disorder, obsessive compulsive disorder, and dissociative identity disorder.	Explores students' experiences of disclosing mental health difficulties at student health services. Most students didn't disclose mental health difficulties at university and actively tried to hide these difficulties. Most who disclosed received helpful assistance with both their studies and management of their mental health condition.
Chen, Ying-Chi Lai, & Yang (2013). USA	Aimed to examine the decisions, practices, and consequences of mental illness disclosure in Chinese immigrant communities in New York	Qualitative, content analysis	53 Chinese Psychiatric Patients	Schizophrenia (58.5%); schizoaffective disorder (22.6%); other diagnoses (e.g., bipolar or depression with psychotic features, or psychosis not otherwise specified; 18.9%).	Found participants disclose to a small circle of friends, family, and relatives. Multiple themes emerged regarding what promoted and discouraged disclosure. Many outcomes including negative judgements by some, increased support from others.
Wood, Bolner, & Gauthier (2014). USA	The purpose of the study was to ask students to describe their experiences of hearing other students self-disclose mental health concerns in the classroom.	Qualitative, phenomenological	21 undergraduate students	Mental health, unspecified	Themes of concern, discomfort, interest, respect, indifference, and enhanced understanding were found.

Quality of Included Studies

The NICE (NICE, 2012) and MMAT (Pluye, et al., 2011) quality checklists, including the ratings for each criteria, can be seen in Appendices B to G. Four questions relating to follow-up data from the NICE quantitative checklist were removed as they were not applicable to the majority of the research examined, so added little value to the overall quality assessment. Overall, the quality of the reviewed research was generally good, with all articles adding value to the review. Regarding the quantitative checklists, there were a few notable areas where quality was lower. Few articles (n=3) discussed power calculations or included confidence intervals to determine the impact sizes of their independent variables. Despite this, the research generally used large sample sizes for the research; ranging from 90 to 748 participants, which may to some extent reduce the chance of inaccurate reports of positive findings which can occur when power calculations are not undertaken.

Many of the studies (n=5) used student participants rather than more randomised sampling which might have more accurately represented the populations considered. Much of the research used constructed vignettes (n=5), rather than actual disclosures; allowing better experimental control and increased internal validity, but at the expense of ecological validity. An additional point of consideration is the applicability of the findings to the UK. The majority of the research was completed in the USA or Europe with some of the research focussing on specific USA communities, like Chinese Immigrants. It is not explicitly clear how applicable research from these different countries and cultures may be to UK populations. Taken together, these considerations meant that although the internal validity of the research was high, the samples, use of vignettes, and research locations meant that it was not possible to rate the external

validity or ecological validity highly; so that caution must be taken when generalising the research findings to the wider UK population.

The picture was similar in the qualitative studies, where the research was generally good quality, with most articles covering most of the criteria. The highest scoring criteria related to having defensible or rigorous designs, and convincing findings which were clear and relevant to the research questions. The criteria least met by the qualitative research were the role and values of the researchers not being explicitly and clearly defined, and there was not always clear and coherent reporting of ethics. Though the clear reporting of ethics is an important issue, it may not have a major impact on the quality or accuracy of the conclusions drawn. However, not defining the role and values of the researchers may mean that it is hard to separate what of the findings may relate to the researchers' values and beliefs, compared to the beliefs and values of the participants. One article, Martin (2010), scored low on many of the quality criteria; the methodology was not rigorously designed, it was not clear how trustworthy the findings were, and the analysis was not especially rigorous. This may reflect the exploratory nature of the research, but the conclusions of this specific paper should be taken cautiously without further research being completed on the studied area.

The MMAT quality checklist (Pluye, et al., 2011) to some extent permitted comparison of the quantitative versus the qualitative research. With the exception of the Martin (2010) study, there were no major discrepancies in the quality of the research; with both qualitative and quantitative research contributing valuable findings and information to the review. However, across both the quantitative and qualitative research there was large variability in the mental health problems considered; some looking into mental health broadly and others examining specific psychiatric diagnoses.

This may impact upon how comparable the different research articles are, where it is unclear if the broader research will apply to specific diagnoses, and equally unclear whether findings around specific diagnoses can be considered more broadly. A final point of consideration is the age of the research, the vast majority of which took place in the 2000s onwards (n=11). However, one article took place in the late 1980s. This may be particularly relevant considering changes over time in how mental health difficulties are viewed in wider society and how people with mental health difficulties are supported in mental health services.

Synthesis of Findings

The articles examined looked into the effects of disclosing mental health difficulties; including how disclosing may impact on how the individual is viewed by others, how disclosure impacts on mental health, and how disclosure may impact on other people. A few articles examined variables that might impact on the outcome of disclosures; including the characteristics of the person disclosed to, and the language used by those disclosing and responding to disclosures.

The effects of disclosure on how the individual is viewed or treated

Some of the articles (n=5) reported effects of disclosing mental health difficulties on others' perceptions of the disclosing individual. Gurtman (1987) examined whether "depressive disclosures" and displays of sadness led to negative evaluations of the individual. The research required psychology students to listen to audio recordings of disclosures and video segments of an individual displaying emotion. The research participants had to rate the individual in terms of whether they would reject them, their

adjustment/maladjustment, their ability to fulfil certain roles, and in terms of traits associated with “devaluation” (such as low warmth, pleasantness, and friendliness). The results suggested that both displays of sad emotion and “depressive disclosure” led to negative evaluations of the discloser.

Though the effects of “depressive disclosures” were considered in Gurtman (1987), it is not explicitly clear whether individuals in the research perceived the individual to be experiencing depression. Mendel, et al. (2015) looked into whether disclosing a diagnosis of depression in the work place increased the risk of stigmatisation and discrimination in workplace settings. The research involved 748 managers in Germany who were shown identical vignettes describing an employee’s recent difficulties. The vignettes were accompanied by different “diagnoses” used to explain the employee’s difficulties: depression, burnout, private crisis, or thyroid problems. The managers were then required to rate the employee on different variables relating to the employees expected job performance. The results suggested that managers were more critical towards the employee when their difficulties were mental health related (e.g. depression, burnout) rather than somatic (thyroid problems). The employee was also expected to be more open about their difficulties and perceived to require more support when the experiences were understood to be mental health related.

As suggested in Mendel, et al. (2015), other people can be critical and rejecting of people who disclose mental health problems. In order to see if this judgement could be combatted Jastrowski, et al. (2007) examined the impact of preventative disclosure for adults with a diagnosis of ADHD. The sample of 306 students read vignettes which were suggestive of “hyperactive” or “inattentive” behaviours and where it was or wasn’t disclosed that the individual had a diagnosis of ADHD. The students then had to

respond to 16 questions about the individual relating to socially rejecting attitudes and potential benefits with treatment. When the diagnosis was disclosed the participants showed significantly fewer socially rejecting attitudes. Furthermore, participants suggested that the individual would more likely benefit from treatments if the diagnosis was disclosed; a finding which was greater for the “hyperactive” than the “inattentive” vignette (Jastrowski, et al., 2007).

Rather than using vignettes to simulate disclosures, Pandya, et al. (2011) examined responses to actual disclosures of 258 individuals with self-reported diagnoses of schizophrenia or schizoaffective disorder. The article considered who was disclosed to, how people responded to disclosures, and some of the consequences of disclosing using an online survey. How people were treated following disclosure of their diagnosis varied between individuals, with some being treated worse, others better, and others the same. Individuals with a self-reported diagnosis of Schizophrenia reported worse treatment from the police/correctional officers than any other group for being open about diagnosis, but better treatment from parents than any other group. Participants reported both positive and negative consequences of being open about their diagnosis, largely depending on which individuals they disclosed to. Some of the reported consequences included: 85% being treated as if they lacked intelligence, 80% hearing negative comments, 71% reporting someone was afraid to be left alone with them, 91% reported someone had avoided the topic of their diagnosis at least once, and over half reported that someone they relied on became more distant since hearing about their diagnosis. Over half of respondents, particularly women, reported that their medical conditions were taken less seriously if their doctors were aware of their diagnosis.

Qualitative research by Chen, et al. (2013) examined the mental health disclosure of Chinese immigrant communities in New York. Individuals using psychiatric services were interviewed to assess their views of mental health disclosure. Specific mental health difficulties were not assessed in this article, instead participants had diagnoses of Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Depression, and others. Participants reported perceiving many different consequences of disclosing their diagnosis; including negative experiences, experiences of support and care, and some reporting no consequences or interest in the consequences. Some of the negative consequences included alienation, rejection, and avoidance; being looked at/treated differently; change of relationship quality; being criticised, laughed at, or gossiped about; and being despised, discriminated against, or bullied. However, over half of participants reported experiences of support, care, and not being treated differently. This appeared to be when other people normalised the experiences, suggesting that anyone can experience “illness”, or when others showed strong commitment to their relationship. Others reported positive experiences of receiving additional support and care from family and friends following disclosure.

Despite the variability in research design, methodology, and mental health difficulties examined, some tentative conclusions can be drawn about the effects of disclosure on how an individual is viewed or treated. It is clear that this is not black-and-white and that there can be both positive and negative outcomes of disclosure on these variables. Individuals appear to be viewed more positively when their behaviour is understood in terms of mental health problems, than when no other explanation is given. However, in comparison to other explanations for behaviour, such as physical illness, people appear to be viewed less positively when understood to be experiencing mental

health difficulties. The most positive outcomes of disclosure appear to be the potential improvement of close relationships and offer of further support. However, there appeared to also be very negative changes in valuation and treatment, where people feel undermined, feared, avoided, and even denied potentially important medical treatments following disclosures.

The effects of disclosure on mental health and/or recovery

Other research articles (n=4) examined whether disclosing mental health difficulties had an impact on the mental health and recovery of the individuals. Pietruch and Jobson (2012) explored the relationship between self-disclosure of a “psychotic episode” and post-traumatic reactions. The research measured post-traumatic stress, post-traumatic growth, the actual disclosure of participants, their urge and reluctance to talk, and their recovery. The results suggested that self-disclosure of first-episode psychosis was associated with lower levels of Post-Traumatic Stress Disorder (PTSD), higher levels of post-traumatic growth, and greater recovery. Lower PTSD symptoms, high actual self-disclosure, and not feeling reluctant to talk were significantly associated with higher post-traumatic growth; but only low levels of PTSD significantly predicted recovery. Recovery was found to mediate the relationships between self-disclosure and post-traumatic growth. Other articles looked into mental health problems more generally, rather than at specific difficulties. Bos, et al. (2009) explored the relationships between disclosure of mental health difficulties, perceived stigmatisation, perceived social support, and self-esteem. The research found that perceived social support and self-esteem were positively associated with disclosures, and that stigmatisation was

negatively correlated with disclosure. The article also reported that disclosure moderated perceived stigmatisation and self-esteem.

Corrigan, et al. (2016) looked at individuals with mental health problems' views about the benefits of being out (BBOs) about their mental health problems versus the reasons for staying in (RSIs). The terms "in" and "out" were used when an individual was reportedly open (or not open) about their mental health diagnosis within their immediate social group (family, friends, etc.), similar to how the terms may be used when individuals disclose homosexuality or other LGB status. For individuals "out" about their mental health diagnosis, endorsing the BBOs was not associated with basic psychological needs, however it was associated with viewing medication as personally effective and being more likely to seek care from either professionals or others in their social group. There was also a negative relationship found between endorsing RSIs and autonomy; suggesting people with increased autonomy value RSIs less. However, "coming out" about mental health difficulties did not appear to affect depression. Overall, the research suggested that an individual's view of the BBOs and RSIs may have a notable effect on their engagement with support.

Martin (2010) examined personal experiences of mental health difficulties in university students. The research was exploratory in nature and reported that the majority of students did not disclose their mental health difficulties at university and actively tried to keep these difficulties secret. Despite this, the vast majority of those who did disclose about the mental health to university staff reported finding the interaction helpful as it led to special considerations such as coursework extensions for university work and additional support from the university. However, some reported

embarrassing and uncomfortable responses which damaged relationships with the university.

It is necessary to be cautious when drawing conclusions from the research around the effects of disclosure on mental health and/or recovery due to the high variability in research methods, areas of study, and quality. Furthermore, the quantitative articles used correlational methods, making it difficult to draw conclusions around causation. In summary, the research appears to suggest that disclosing mental health difficulties may be associated with positive variables such as post-traumatic growth, self-esteem, perceived stigmatisation, recovery, and access to social support and support from mental health professionals.

The impact of the person disclosed to

A small number of studies (n=2) examined how the individual disclosed to might impact on the effects of disclosing mental health difficulties. Burke, et al. (2014) looked into how attachment avoidance and the gender of the person disclosed to may impact upon responses to disclosures of depression; using a two part study. The first part showed vignettes presented with slightly different information. The individual was either described to experience depression, recurring physical pain, or injuries with no long-term impact, and to be either relatively open or relatively secretive about this information. Participants were asked to complete rating scales around how they feel about the person in the vignette generally, how warm they see them to be, and how competent they think they are. Female participants overall preferred the individual when they disclosed, regardless of the reason for the difficulties. Male participants did not

view the individual more positively for disclosing in the depression condition, but did for the other conditions. Similar conclusions were drawn for warmth and competence.

The second study hypothesised that another predictor of response to disclosure may be attachment avoidance; where individuals are less open about emotions and may be more anxious with emotional intimacy. This study again used a vignette but focused solely on depression rather than other explanations for difficulties. Participants again had to rate the individual on the same variables (general feelings towards the person, warmth, and competence), but also completed a measure of attachment avoidance. Participants were found to view the individual more positively for disclosing on the three measures, except men who were high in attachment avoidance, who viewed the individual less positively for disclosing. Overall, the article suggested that the gender and level of attachment avoidance of the individual disclosed to may have a notable effect on how the discloser is viewed.

The aforementioned research by Bos, et al. (2009), which examined the relationships between disclosure, perceived stigmatisation, perceived social support, and self-esteem, also came to conclusions about the effects of which individuals are disclosed to. They found that participants perceived the least social support and most stigmatisation from acquaintances and colleagues, and the most social support and least stigmatisation from their partner and parents.

As with other areas in this review, it is only possible to draw tentative conclusions based on the small amount of information available. Together, the articles considering the impact the person disclosed to could have on outcomes of disclosing mental health difficulties appear to suggest that the impact is significant. Individuals' responses to disclosures could potentially be highly variable, with positive outcomes

more likely when disclosing to a partner or family member and negative responses more likely when disclosing to those less close; such as acquaintances or people who are more avoidant of relationships and the sharing of emotions.

The effects of how mental health is disclosed

Two articles examined the details of how an individual may disclose their mental health difficulties, the specificities of the response to these disclosures, and the outcome of the disclosure. For example, Scott, et al. (2013) first looked into the ways depression could be disclosed and how this might impact upon the “sophistication” of responses. They then looked into how individuals with depression diagnoses viewed those potential responses. In the first study participants were asked to write how they would respond to presented depression disclosures. It was hypothesised that, when disclosing, individuals have different and multiple goals. The disclosures were varied in terms of presenting just the disclosure, poor coping, good coping, balanced coping, or explicit support-seeking. The responses to disclosures were coded into three categories, described as increasing in “sophistication” and hypothesised to be increasingly more helpful: “expressive” responses which simply communicated thoughts and/or feelings, “conventional” responses which contained socially normative ideas of how to respond, and “rhetorical” responses which appeared to attend to multiple goals and often tried to go against or redefine expectations. The majority of responses were coded as conventional, followed by expressive, then rhetorical. The balanced or help-seeking disclosures appeared to generate more sophisticated responses; conventional rather than expressive.

In the second part of the research by Scott, et al. (2013) individuals with depression diagnoses rated the responses in terms of their appropriateness and supportiveness. As hypothesised, more sophisticated responses were viewed as more supportive; with expressive responses being least supportive and rhetorical responses being most supportive. The sophistication of responses had no impact on ratings of appropriateness. Overall, the research suggested that the goals and language used by individuals disclosing depression can have a major impact on the responses received, so that disclosures may impact upon how supportive the responses are.

Gurtman (1987) also examined how the emotion an individual displays, and the language used when disclosing, may impact upon how the individual is viewed in terms of whether others would reject them, their adjustment/maladjustment, their ability to fulfil certain roles, and whether they would be devalued. The article suggested that when a person does not give verbal “depressive disclosures”, the emotion they display, particularly sadness, can lead to rejection, devaluation, and other negative appraisals. However, the emotion displayed appeared to be of less impact when a person also disclosed information verbally. When “depressive content” was also present in the disclosure the individual was further rated negatively in terms of the variables measured.

Together, the two articles suggest that the language and emotions displayed in disclosures of mental health difficulties can affect how they are viewed and how people respond. More specifically, people appear to view the person disclosing worse and respond in less helpful ways if the person is highly emotional or displays poor coping. Furthermore, people appear to offer more helpful responses when an individual shows balanced coping or directly asks for support.

The effects of disclosure on other people

When assessing the effects of disclosing mental health problems this could include the effects on the people disclosing but also on the people disclosed to. The vast majority of the research considered relates primarily to the former. In a few articles, such as Jastrowski, et al. (2007), the attitudes of the people disclosed to were considered. However, the focus of these articles was on how the disclosures affected appraisals of the disclosing individual as opposed to effects on the people disclosed to themselves; such as the impact on their own wellbeing, their values in relation to mental health, or their wider views in relation to people with mental health problems. One article in the review considered the effects of disclosure solely in relation to the individuals disclosed to. Wood, et al. (2014) looked at undergraduate students' experiences of hearing mental health disclosures in the classroom. The student participants were interviewed about their experiences and the interviews were analysed using a phenomenological qualitative methodology. The research found six themes relating to how the participants felt following the disclosures; including enhanced understanding, respect, concern, discomfort, interest, and indifference. The authors suggested that overall participants experienced disclosures of mental health difficulties in the classroom positively. Only the single article by Wood, et al. (2014) was able to provide some insight into the effects of mental health disclosure on other people, leading to the tentative conclusion that disclosures could potentially have both positive and negative effects on the people disclosed to.

Discussion

The aim of this systematic literature review was to consider the impact/effect of disclosing mental health difficulties. Perhaps some of the most notable findings pertain to the nature of the literature base itself, rather than specific findings gathered from the articles, and how thoroughly this allows the research question to be answered. As highlighted in the results section, although the quality assessment indicated that the overall research quality was good, large variation within the twelve reviewed papers was noted. This variation occurred in many different ways, including the overall methodologies used (quantitative vs qualitative), the specific methods used within the overall paradigm (surveys vs experiments vs interviews), the types of participants used (general population vs students vs clinical samples), disclosure types (real vs vignette), who is disclosed to (general public vs employers vs family) and the mental health difficulties considered (mental health difficulties generally vs specific diagnosis). The large inconsistencies in approach taken may give some indication to how new the research area is, where the effects of disclosure were previously not considered. This is further supported when considering the years in which the papers were published, with only one from the 1980s, two from the 2000s, and nine from the 2010s. This appears to suggest an upwards trend in recognition of the importance of mental health and disclosing mental health difficulties. This similarly may suggest that, as the research area evolves, there will likely be more exhaustive answers to questions around the effects of disclosing mental health difficulties. This however means that at present when considering the conclusions drawn from the current research, it is important to be mindful of the novelty of the research area and variation within the literature base.

With the discussed difficulties in mind, it has been possible to draw a few tentative conclusions about disclosure and its impact on the perception of an individual, impact on their recovery and mental health, and the impact on those disclosed to. The studies reviewed also suggest that there may be two variables that could mediate these effects; how disclosure happens and to whom.

Regarding the effects of disclosure on how individuals are viewed and treated, articles came to varying conclusions. Some came to the conclusion that individuals will be devalued, believed to be less capable, viewed more critically, and experience more stigmatisation (Chen, et al., 2013; Gurtman, 1987; Mendel, et al., 2015; Pandya, et al., 2011), others to the conclusion that disclosure may reduce social rejection and increase social and professional support (Chen, et al., 2013; Jastrowski, et al., 2007; Pandya, et al., 2011). This variability in conclusions may be for many different reasons, including that articles looked at different mental health difficulties which may not be appropriately comparable (e.g. ADHD, depression, psychosis, etc.), different methods were used (vignettes vs clinical participants), and the individuals disclosed to differed (student participants, family, managers, etc.). In addition to the methodological variability which may impact on how an individual is viewed or treated, the variability may also, or alternatively, reflect the complex nature of the experience. For example, research on the Gay, Lesbian, and Bisexual community's experiences of "coming out" similarly report variable outcomes; including increased acceptance and improved relationships, but also an increased risk of experiencing stigmatisation and violence; so that the complex and variable outcomes from disclosing mental health difficulties may reflect the impact of disclosing stigmatised experiences (Corrigan & Matthews, 2003).

Some of the ways individuals reported being treated as a result of having disclosed their mental health difficulties may have a serious impact on physical, mental, and social health. Pandya, et al. (2011) noted that individuals diagnosed with Schizophrenia reported being taken less seriously when they reported physical health problems to medical professionals after the professionals were aware of their diagnosis. This may be particularly damaging to these individuals when it is known that treatments for mental health difficulties, like psychiatric medications, are known to have potentially harmful physical effects which require close monitoring (De Hert, et al., 2011; NICE, 2015). The authors suggested that this disregard may contribute to the premature death rates of individuals with mental health difficulties (Pandya, et al., 2011). Similarly, Mendel, et al. (2015) suggested that individuals are viewed to be less competent and capable when managers are aware of mental health difficulties. This is concordant with literature on the larger stigma of mental health difficulties and associated economic damage the stigma can cause (Sharac, et al., 2010).

The research on the impact of disclosure on mental health and recovery also had variable conclusions; such that it may be beneficial for mental health in some cases, but detrimental in others. The correlational nature of many of the articles meant that it is not clear whether disclosure is a causative factor of improved mental health, a result of improved mental health, or that both are affected by other variables (Bos, et al., 2009; Corrigan, et al., 2016; Pietruch & Jobson, 2012). When comparing these findings with prior literature reviews, it could be hypothesised that the stigma individuals face following disclosure may reinforce previous fears of negative responses to disclosure or reduce these fears thus supporting mental health, depending on the responses of the individuals disclosed to (Clement, et al., 2014; Wahl, 1999). The stigma and responses

may then also impact on whether individuals further seek professional and/or social support (Bos, et al., 2009; Corrigan, et al., 2016; Martin, 2010; Pietruch & Jobson, 2012). The use of participants within mental health services in many of the articles may make it difficult to distinguish the impact of disclosure on mental health for those who do not access these services. For example, it could be hypothesised that those who experience the most stigma or have disclosed to people who discourage access to mental health services, may experience damage to their mental health, but not be recognised in the literature.

The literature directly examining the impact of the person disclosed to on the effects of disclosure appeared to suggest that this may have a large impact upon the outcome (Bos, et al., 2009; Burke, et al., 2014). Burke, et al. (2014) considered specific variables which may effect the outcome, gender and attachment avoidance, whereas Bos, et al. (2009) considered the reports of individuals who had disclosed. The authors of these articles and of other articles which did not specifically examine this area appropriately recommend that a selective approach to disclosure may lead to the least stigmatising and most supportive responses to disclosures (Bos, et al, 2009; Burke, et al., 2014; Corrigan, et al., 2016; Pandya, et al., 2011).

The results also suggested that it is not just important to consider who is disclosed to, but also the content and process of the disclosure (Burke, et al., 2014; Scott, et al., 2013). Both articles on the effects of how disclosure takes place imply that highly emotional disclosures which suggest poor coping appear to illicit more negative judgements and responses (Burke, et al., 2014; Scott, et al., 2013). This may suggest that disclosures which are planned, thought out, and delivered calmly may produce the most supportive and useful responses. This hypothesis is supported by evidence that

tools which support disclosure can lead to more supportive and less stigmatising outcomes (Hielscher & Waghorn, 2015). For example, the CONceal or ReveAL (CORAL) decision aid is a tool which includes information about the pros and cons of disclosing, disclosure needs and values, and when and whom to tell, with the aim to supporting people in their decision to disclose mental health difficulties to their employers. A randomised controlled trial into the value of CORAL showed significant reductions in decisional conflict and improvements in employment status at three months compared to controls (Henderson, et al., 2013). Similarly, a pilot randomised controlled trial into the effects of Coming Out Proud, a three week peer-led group intervention which offers support around the negative effects of mental health stigma, found positive effects on stigma stress, disclosure-related distress, secrecy, and perceived benefits of disclosure (Rüsch, et al., 2014).

Methodological Limitations and Future Research

The most notable limitations of the review relate to the research available for examination, where few articles were available to address the review question. Furthermore, the available research was of high variability in terms of research methods, participants recruited, areas of enquiry, and other variables. This means that any conclusions drawn in the review must be taken with caution. Equally important is the poor external/ecological validity of many of the research articles examined, which limits how applicable the results may be to real world settings. The wide range of mental health difficulties examined similarly makes it harder to draw valid conclusions about mental health as a whole, or about specific mental health difficulties.

Given the sparsity of research found pertaining to the research question, and the methodological flaws within the literature, there is very clear scope for further research in many areas relating to mental health disclosure. The review highlighted that there are many different outcomes which can occur following disclosures; such as changes in others' perceptions, changes in mental health treatment received, and changes for other people as well as the person disclosing. Additional research could aim to better understand what factors lead to the variety of outcomes. This may then support the development of more informed advice for people who wish to disclose their mental health difficulties, in addition to providing information to support those who may be distressed by disclosures (such as family and friends).

Furthermore, this review noted high variability in terms of who discloses, what they disclose, who they disclose to, and what outcomes are measured in the research. More consistency in measurements used and types of disclosures in future research may improve comparability between findings. The review also highlighted that disclosing different mental health difficulties can have different outcomes. Comparison of different diagnostic groups in research should provide further insight into this, so that a one size fits all approach is not taken when considering disclosure. A small amount of research considered disclosure from the perspectives of people who have disclosed in the real world (such as people in mental health services) as opposed to using vignettes; where possible, future research may also wish to use similar more ecologically valid ways to consider the effects of disclosure. Such research may also provide useful narratives for people who are considering disclosing their own mental health difficulties. Finally, none of the research discussed considered the longer term effects of disclosing mental health

difficulties, meaning that further research may help to better understand what effects, if any, there are over the long-term.

Social and Clinical Implications

Perhaps the most notable social implication from this review pertains to how overlooked the research area has been. This may indicate that the area has not largely been viewed as important or that disclosures have not been considered an influential factor pertaining to mental wellbeing despite the levels of stigma and discrimination associated with mental health (Clement, et al., 2014; Ma, 2017; Wahl, 1999). More open discussion and consideration about mental health disclosure in both mental health services and wider society may support awareness of this. Furthermore, the recognition that mental health disclosure can affect the discloser, people disclosed to, and wider societal views supports the expanding understanding of the social nature of mental health (World Health Organisation, 2014).

Though the clinical implications need to be considered cautiously due to methodological limitations of the literature, there are a few considerations which may help mental health professionals to support service users. How and to whom an individual discloses their mental health difficulties may have an impact upon their physical and mental health. Mental health professionals could therefore support people with mental health difficulties to carefully consider if they wish to disclose, and if so how and to whom they would do so if they have not done so already. Tools which support informed disclosures, such as “CORAL” and “Coming out Proud”, could potentially support this (Henderson, et al., 2013; Rüscher, et al., 2014).

However, as it is likely that people will have disclosed their difficulties to family, friends, or a partner prior to entering mental health services, it might also be of value to enquire into mental health services users' experiences of disclosing their mental health difficulties. These experiences may shape the individuals' use of services, their self-esteem, recovery, and other important variables. Family, friends, and others close to individuals with mental health difficulties may be an important source of support, distress, or both for the individual. Supporting an individual with mental health difficulties may be more fruitful when the experiences and impact of others around them is considered.

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Part Two: Empirical Paper

This paper is written in the format ready for submission to the journal

Journal of Clinical Psychology

Please see Appendix H for the submission guidelines

The experience of talking about hearing voices with family, friends, and others

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Abstract

Objective: Voice hearing is often understood in the western world as a sign of mental illness, a problem within the individual. However, there is evidence to suggest that close social networks and wider social influences have a major impact upon people who hear voices. The aim of this research was to explore people's experiences of talking about hearing voices with family, friends, and others. **Method:** Six participants were recruited through mental health services and interviewed. The interviews were analysed using Interpretative Phenomenological Analysis (IPA). **Results:** Three superordinate themes, each with multiple subordinate themes, were developed from the interviews: "*I just wanted to know what was going on*", "*Who can I talk to about this?*", and "*I was shocked by how they responded*". **Conclusions:** The research findings are compared to the existing literature, limitations of the research are considered, and recommendations based on the findings are discussed.

Introduction

Voice hearing can be described as the experience of hearing voices that are not recognised as our own thoughts when there is no known external stimulus causing the voices; or more simply as “hearing voices speaking when there is no-one there” (British Psychological Society, 2014, p.10). Voice hearing is considered by many in western society to be a symptom of mental illness, which is to be eliminated, usually by the use of psychiatric medications (World Health Organisation, 1992). Despite this, there is growing evidence that voice hearing can occur in healthy populations (British Psychological Society, 2014). A review of research articles examining the prevalence of voice hearing in the general population estimated that across the lifespan between 0.6% to 84% will experience voice hearing, depending on the exact definition (Beavan, Read, & Cartwright, 2011). The review gave a median of 13.2%, suggesting that the experience is much more common than was previously believed (Beavan, et al., 2011; Romme & Escher, 1989; British Psychological Society, 2014). Given that over one in ten people may experience voice hearing, a clear and accurate understanding of it is important. One way to develop this is by considering how people who hear voices experience and make sense of the phenomenon.

Making Sense of Hearing Voices

Romme and Escher (1989) suggested that individuals who hear voices go through a series of phases as they come to make sense of and adapt to their experiences. Initially, participants described feeling frightened and confused as they began to hear voices, with a strong desire to escape the experience. Following this, came a process of selection and communication with the voices. Participants often expressed anger

towards the voices or attempted to ignore them in order to rid themselves from the experience, usually finding this a fruitless endeavour. The most helpful strategies involved communicating with the most positive voices and attempting to understand them. Eventually, many participants found a more continuous way of being present with the voices, often seeing them as parts of themselves and their lives. At this point, participants would listen to the voices, take their advice (or not), and potentially see them as a positive part of their life (Romme & Escher, 1989). The paper emphasised the commonality of voice hearing outside of psychiatric services and considered that it may be unhelpful to view the experience as purely psychiatric. Accepting the person's experience of voices, understanding their frame of reference (spiritual, biological, psychological, or otherwise), encouraging communication with voices, and encouraging meeting other voice hearers was endorsed (Romme & Escher, 1989). Though the research recognised that people go through stages of learning to understand and relate to the voices, the influence of other people was not recognised. For example, when an individual first begins hearing voices, comfort and understanding could be sought from those closest to the individual. Without considering this, the potential influence of other people in understanding experiences of voice hearing may be neglected.

Research by Holt and Tickle (2015) examined how individuals who hear distressing voices made sense of their experiences. In their research, many participants understood their experiences from multiple perspectives rather than having a single explanation about the nature of their experiences. Biomedical explanations were not recognised as superior to other explanations despite the cultural dominance of these approaches (Holt & Tickle, 2015; British Psychological Society, 2014). Holt and Tickle (2015) developed theory, suggesting that people made sense of their voice hearing

experiences through three meaning making processes: intrapersonal (with one's own thinking and reflection), interpersonal (with the help of others), and parapersonal (beyond a person's control but part of them, e.g. biological or spiritual). They suggested that current mental health services might hinder this process when strictly biological explanations undermine the individual's own meaning making and suggested that any stigma could further hinder this process by discouraging communication.

The work of Holt and Tickle (2015) recognised that interactions with other people can have a major influence on how people make sense of their voice hearing experiences. Influences could include interactions with family, friends, colleagues, ideas in wider society, and health services. Therefore, when attempting to understand the experience of voice hearing, an individual should not be considered outside of their wider social context (British Psychological Society, 2014). Furthermore, given that people who hear voices will likely use the conversations and ideas around them to make sense of their experiences, it is necessary to consider what these ideas (or constructs) are and the impact they may have on people who hear voices.

The Impact of Other People on the Experiences of Voice Hearers

Constructs of voice hearing in western society

Vilhauer (2015) examined US newspaper articles in an attempt to see how voice hearing is understood by the general population, under the premise that news articles will reflect views of the general public. Few articles (12.7%) gave any indication that voice hearing could occur in psychologically healthy individuals. Those that did related to religious or spiritual overtones or about dispelling myths about voice hearing. Most articles suggested that voice hearing is indicative of mental illness; with 51.9% of articles

implicating voice hearing in criminal behaviour, 47% with violence, and 18.2% with suicidality. It is worth noting that the research specifically looked at US newspapers so may not reflect the views of UK populations (Vilhauer, 2015). Though not discussed in the research study, it is important to recognise that the media may both reflect societal views on a topic, but also contribute to societal views, operating within a reciprocal causality (e.g. Champion & Furnham, 1999; Coleman, 1993; Enric, Lopez-Muntaner, Ceruelo, & Barosa, 2014).

Research examining how people who hear voices believe they are perceived by others report similar findings. Several studies have reported participants' feeling concerned that they were "mad", that they could be dangerous to themselves or other people, that they are not "normal" and will never be "normal" again, and that they had to keep their voices secret so as not to experience stigma and discrimination (Holt & Tickle, 2015; Kalhovde, Elstad, & Talseth, 2013; Knight, Wykes, & Hayward, 2009; Mawson, Berry, Murray, & Hayward, 2011). These beliefs are sadly not unfounded, with those with diagnoses associated with voice hearing, such as Schizophrenia, often experiencing violence and discrimination from the public (Knight, et al., 2009; Mawson, et al., 2011; British Psychological Society, 2014). It is evident that constructs of voice hearing often paint these experiences in frightening and inaccurate ways, and that people who hear voices can experience stigma and discrimination because of it.

The influence of family, friends, and other close people

In addition to being affected by constructs in wider society, people who hear voices can also be affected by family, friends, and partners. Research around "expressed emotion" has considered the impact of families on people diagnosed with Schizophrenia: a

psychiatric diagnosis associated with voice hearing (American Psychiatric Association, 2013). In this context expressed emotion refers to how critical, excessively involved, and invalidating of experiences families may be towards the individual with a diagnosis of Schizophrenia. High expressed emotion in families is associated with poorer mental health, recovery, and relapse in those with a diagnosis of Schizophrenia (Amaresha & Venkatasubramanian, 2012; Butzlaff & Hooley, 1998). The articles recognise the potential impact of others on individuals who hear voices. However, these studies only assessed people with a diagnosis of Schizophrenia; meaning it might be fallacious to suggest this is the case for all individuals who hear voices. Furthermore, rather than being a problem of the individual or the family, this research may indicate a crisis in a family system, where many individuals in the system can experience distress.

Other research has examined the relationship between voice hearers' real world relationships and their relationships with their voices, finding that relationships with voices often mirror the experiences of relating with others socially, with voices often bearing similar characteristics to abusers, bullies, and others (Hayward, 2003; Mawson, et al., 2011; Corstens & Longden, 2013). Another potential influence on this is perceived social rank, both in relation to real world others and voices. It is suggested that perceived stigma from others can encourage people to take a 'submissive' rank in society, where the individual is perceived, and believes themselves, less powerful than others in society. Some articles have suggested that those perceived to be of lower social rank to the rest of society and/or to their voices have greater difficulties with anxiety and low mood (Birchwood, Iqbal, Chadwick, & Trower, 2000; Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000; Birchwood, et al., 2006). Based on this information it could be expected that those individuals with more supportive families

and loved ones may find coping with and relating with their voices better. Equally it could be hypothesised that those with more critical and stigmatising families may find their voices more overwhelming and difficult to live with.

Research Area and Rationale

Though research has examined the individual experiences of people who hear voices and how wider society may impact upon them, no research has yet enquired about the direct experiences of people who hear voices in relation to family, friends, and partners. The intention of this study was to understand, based on the experiences of those who hear voices, what the experiences of talking about voice hearing to close people is like. This included family members, friends, colleagues, partners, and other people the individuals felt may have influenced their experiences of voice hearing.

Research which studies people's experiences of hearing voices is needed for many reasons. Despite there being little research into the experiences of people who hear voices, there are large sums of money spent on supporting individuals with these experiences; the estimated cost of "schizophrenia" in England was 11.8 billion pounds in 2012 (Andrews, Knapp, McCrone, Parsonage, & Trachtenberg, 2012). Without a clear understanding of the experiences, mental health services may not be providing the most suitable care for their clients and their families (British Psychological Society, 2014). Research has frequently reported on inaccurate and stigmatising understandings of people who hear voices, with suggestions that all people with these experiences are "mad", dangerous, and suicidal (Knight, et al., 2009; Vilhauer, 2015). The Hearing Voices Movement, a national group which promotes non-pathological understandings of voice hearing, has called for research that values the views and experiences of voice

hearers, rather than a focus on psychiatric labels and illnesses; with the aim of further promoting an accurate and respectful understanding (Corstens, Longden, McCarthy-Jones, Waddington, & Thomas, 2014).

Research Aims and Questions

This study aimed to explore how individuals who hear voices experienced talking about this to people they have a close relationship with; whether this was family, friends, a partner, or any other person the individuals chose. Through this research it was hoped that the experience of talking about voice hearing with others and the consequences of this would be better understood. The research question was:

How do people experience talking about hearing voices to the people they consider close to them?

Methods

Design

Multiple approaches, such as those which enquire into power, discourses, causes and effects, or narratives, may have provided valuable information related to the research area; such as how voice hearing may be constructed by language in society, how people structure stories about their voice hearing experiences, or the underlying mechanisms associated with voice hearing. However, as the research question specifically enquired about individuals' experiences of a particular phenomenon (voice hearing) and their understanding of their experiences, a phenomenological qualitative approach was viewed to be particularly appropriate (Howitt, 2010).

Interpretative Phenomenological Analysis (IPA) is a qualitative methodology particularly interested in how people experience and make sense of a particular phenomenon. IPA was used to help capture the personal experiences of the participants (Smith, Flowers, & Larkin, 2009). In IPA the researcher's role is to examine research participants' interpretations of the phenomenon of enquiry, then offer their own interpretation of what they have understood. As the researcher had an active role in interpreting the data, their beliefs, experiences, and values were considered and recorded in order to ensure transparency in the analysis (Howitt, 2010; Smith, et al., 2009). Information on the researcher is provided in the "Researcher Position" statement.

The research used individual semi-structured interviews which were informed by an interview schedule (See Appendix I). The questions for the schedule were initially developed through consideration of the existing literature pertaining to voice hearing experiences (Corstens, et al., 2014; Holt & Tickle, 2015; Romme & Escher, 1989). A local Hearing Voices Group consisting of six individuals, who had experiences of hearing voices, was consulted about the research design and interview schedule questions. The interview schedule was also then piloted with one individual who had heard voices and was known to the researcher. Data from this interview was not included in the final analysis but was used to provide further guidance for the interview schedule. The schedule was not followed dogmatically, but instead used to offer prompts to encourage participants to consider their experiences in depth during interviews. The research was reviewed by the North East - York Research Ethics Committee who gave a favourable opinion.

Participants

In order to take part in the research participants had to meet a set of inclusion and exclusion criteria, to ensure that a homogenous sample, appropriate to answer the research question, was selected (Smith, et al., 2009). These criteria included: the participant had heard voices and had spoken about them with one or more people they consider ‘close to them’, such as family, friends, or a partner; were at least 18 years old; were fluent in English; were of sufficient ‘mental stability’, as assessed by their care-coordinator/key worker, to be able to discuss potentially upsetting material without risking further psychological disturbance; and were able to fully understand the process of the research and give informed consent.

Seven participants were recruited from local Community Mental Health Services, however one participant did not attend their interview, and could not be contacted to rearrange, leaving six participants in total. All participants were White-British and from the local area. Pseudonyms and further demographic information is provided for each participant in Table 1.

Table 1: Participant pseudonyms and demographic data

Pseudonym	Age	Gender	Years Heard Voices (as a percentage of age)
Janet	47	Female	29 (62%)
Trevor	44	Male	31 (70%)
Paul	51	Male	22 (43%)
Lucy	24	Female	8 (33%)
Daniel	44	Male	17 (39%)
Fred	53	Male	33 (62%)

Though the interview with Paul added to the overall interpretation and understanding of the research data, the interview did not provide any quotes relevant to the research question, so none have been included in the results section of the research.

Procedure

Information sheets (see Appendix J), which gave information about the research, were shared with care-coordinators and other professionals within the Community Mental Health Teams so they could identify potential participants for the study. The information sheets and attached form for expression of interest were shared with potential participants in order for them to understand the research and state whether they would be happy to be contacted about participating. These forms were returned to the researcher, either directly or via the care-coordinators. Alternatively, the researcher was given the contact details of potential participants directly from staff at the Community Mental Health Team, with verbal consent from the potential participants. The researcher waited 48 hours after receiving contact details before contacting the potential participants, to allow time to consider their choice of participation. Participants were contacted via their preferred method of communication in order to arrange a time and place to discuss the research; allowing further explanation of the research process and opportunity for the participant to ask any questions. If the participant agreed to all the information provided then the consent form was signed (See Appendix K).

The research interviews took place immediately following the pre-interview discussion and signing of the consent form, and lasted 45 minutes on average. The meetings and research interviews, undertaken by the lead researcher, took place either within NHS clinical rooms or at the homes of participants. An information sheet providing information about possible sources of support (See Appendix L) was provided after the research interview. Participants were given the opportunity to discuss the interview and any questions or concerns they had. The research interviews were audio recorded and transcribed verbatim by the researcher.

Data Analysis

The interview transcripts were analysed for themes using the following data analysis procedure, providing the results of the research (Howitt, 2010; Smith, et al., 2009). The transcripts were initially analysed separately, line-by-line, in order for the researcher to become familiarised with the transcripts. Initial thoughts and ideas were noted alongside the text as exploratory comments in order to build an understanding of participants' accounts of their experiences. After this process had been completed with each transcript, the researcher re-analysed the texts for prominent, reoccurring, or unique ideas in order to develop preliminary themes. Two transcripts were also independently analysed by two secondary researchers. This allowed conversation surrounding interpretation; with the aim to promoting rigour, transparency, and self-awareness in the process of analysis (Smith, Flowers, & Larkin, 2009). Preliminary themes and exploratory comments were then compared between all transcripts in order to continue the development of themes. These were again discussed with the secondary researchers to further promote clarity and understanding. Those themes which appeared to reflect ideas prominent across transcripts and provided answers to the research question were then organised to provide the final themes, including superordinate themes when multiple subordinate themes reflected interrelated ideas. Theme titles were developed based on quotes from the transcripts which reflected overall ideas pertinent to each theme (Smith, Flowers, & Larkin, 2009).

Researcher Position

It is recognised that the researcher's values and experiences will to some extent shape the interpretation of the research data, so the following information has been provided to

aid transparency. The researcher is a young white male from Yorkshire, who has attended higher education and trained as a clinical psychologist. The researcher's training in clinical psychology promotes models which particularly focus on understanding clients' perspectives, understanding relationships and interactions, and critical thinking. Furthermore, in this training multiple perspectives on psychological wellbeing are promoted, which recognise the impact of biological, social, and psychological factors. The researcher also recognises their own experiences of interacting with people who hear voices, both in personal and professional settings, which could mean their personal experiences impact interpretation.

Results

Three overlapping and interrelated superordinate themes, each with two to three subordinate themes, were developed from the research analysis. The themes are shown in Table 2 and then described in detail below, with quotes from the research interviews and associated interpretation used to evidence the developed themes.

Table 2: Superordinate and Subordinate Themes

Superordinate Themes	1: I just wanted to know what was going on	2: Who can I talk to about this?	3: I was shocked by how they responded
Subordinate Themes	1.1: I was hearing things they couldn't	2.1: They'll think I'm a monster	3.1: They kind of freaked out
	1.2: What's actually going on?	2.2: I only really talk to my nurse or consultant	3.2: They were really calm and talked it through with me
	1.3: Am I ill or just having different experiences?	2.3: I've been careful when talking about it	

Superordinate Theme 1: I just wanted to know what was going on

The key message of this superordinate theme is that participants struggled to make sense of why they heard voices, frequently using people close to them, as well as mental health services, to support active attempts to understand their experiences.

Subordinate Theme 1.1: I was hearing things they couldn't

This subordinate theme highlights how, prior to attempting to understand why they heard voices, participants first had to recognise that they were hearing voices. Participants were often only able to discover this through interactions with other people, which allowed them to recognise that other people, such as family or friends, had not heard the same thing.

Participants recounted various experiences, feelings, and understandings when they realised other people didn't appear to share their experience of voice hearing. Some participants, such as Trevor, had understood this to mean they had an extra ability, where they could perceive something others could not:

“I realised ... that what I was seeing and hearing things they didn't hear and they couldn't see” (Trevor)

Though at one time this may have felt positive for Trevor, his experiences later became frightening, as he felt he could not accurately perceive reality. He appeared to compare this to being unable to understand morals, which reflected an idea that people who don't accurately perceive reality can be dangerous:

“They got where they was that intense that I was walking around talking to them ... I couldn’t distinguish right from wrong, good from bad, that kind of thing ... what was real, and what wasn’t” (Trevor)

Similar to Trevor’s belief that he could not accurately perceive reality, Lucy appeared to believe she was misperceiving reality, rather than experiencing something others couldn’t. This meant that she would use her partner as if he was an external sensory organ, trusting his perceptions over her own:

“I kind of use him to test out whether it’s actually there or not ... so like if I think I’ve heard something that I might not have, other people have heard, I’ll ask him if he heard anything ... just to kind of test it” (Lucy)

This appeared to be at times frightening for her, as being reliant on others to know what is and isn’t real led to unintended disclosures when they were not around, which meant she was unable to control how others viewed her:

“I was with her and I had this thing about hearing crows ... and they were really loud so I had to leave ‘cos it was bothering me so much and then I, I didn’t realise ... they weren’t there ... I text her and said “oh sorry, I had to leave ‘cos the crows were really loud and they were annoying me” and she was like “I didn’t hear any crows” and I was like “oh god”” (Lucy)

Other participants, such as Janet and Daniel, did not appear to believe that they were misperceiving reality or were hearing things that others couldn't. They instead believed that the people around them must be lying about their experiences so could not be trusted to report an accurate view of reality. This appeared to cause great distress or frustration towards other people:

“I said to ... my partner ... “can you hear, like hear anything” and it’s “no”. I thought he was lying. I thought he was lying to me, do you know ... but, it’s not, it’s not possible, you must be able to hear it” (Janet)

“I said “did you feel that” and he said “no” ... he was a natural born liar anyway, he never told me the truth as it was ... he was a dodgy twat, you know what I mean?” (Daniel)

Across participants, there often appeared to be a conflict between two ideas: they either believed they were misperceiving reality so had to depend on others to know what is real and what is not, or believed they were perceiving reality accurately and other people could not be trusted, leading to conflict and mistrust in relationships.

Subordinate Theme 1.2: What’s actually going on?

This subordinate theme highlights how, after participants had recognised they were hearing voices, they attempted to understand their voice hearing experiences through conversations and interactions with friends, family, and other people around them.

Participants attempted to understand their experiences through concepts in society; such as spiritual ideas, scientific ideas, medical explanations, or genetics. Participants suggested that these attempts to understand their experiences were confusing, frequently changed, and were never certain; using phrases such as *“it could have been”* (Fred), *“I convinced myself that”* (Trevor), and *“at one point I thought that”* (Lucy) when offering possible explanations:

“To be honest with you ... I convinced myself at the time that ... I was seeing ... ghosts and stuff like that ... that’s the only way I could ... properly comprehend what was going on. I used to think to myself, “I can, the reason other people can’t see them is because I’m the only person who can see ghosts” ... and that’s the way I went on about it for a few years” (Trevor)

“At one point I thought that ... the things I was hearing was coming through another dimension ... and that I could ... experience another dimension ... and that’s where it was coming from, like kind of a hole in between” (Lucy)

The conversations participants had with family members, their partner, or others appeared to influence the sense making process, where other people would often offer explanations. However, participants did not always seem to find this useful, instead finding it further encouraged the confusion of understanding the experiences:

“I had a word with my brother ... and he said “don’t be stupid” ... “stop taking that shit all weekend”, and stuff like that ... because he thought it was LSD, he’d

seen I was taking LSD with my friends all weekend ... “if you stop taking that shit at the weekend you’ll be alright”... I stopped taking LSD and amphetamine ... and it never went away” (Trevor)

For Daniel, other people’s explanations at times seemed absurd, which may have reinforced the idea that his experiences are confusing and that other people are not able to understand:

“My mum can, I’ve had two same things, my daughter said “it could be aliens” ... and me mam said “it could be aliens” as well ... but, I think that’s a bit far out” (Daniel)

“He, he thinks I’ve got a split personality [LAUGHS] ... I don’t think I have, ‘cos the voices don’t manifest themselves to me, to make me a different person” (Daniel)

Subordinate Theme 1.3: Am I ill or just having different experiences?

This subordinate theme discusses how participants considered, and often struggled with, the idea that their experiences are frequently understood by many people to be symptoms of a mental illness.

Unanimously, participants had been encouraged to understand their experiences in terms of mental illness. For example, some participants reported that their family and mental health professionals only took their experiences seriously if they were given a

diagnosis or viewed their experiences as illness; as if this diagnosis made their experiences real and tangible:

“[My mother said] “oh, he’s just doing it for attention” [when I was younger]... and then when I was actually diagnosed as erm, paranoid schizophrenic, my mum turned around and said ... “at least you’ve been diagnosed, you’re getting proper treatment” and she was quite supportive” (Trevor)

This idea was so prominent that participants were not trusted as the authority on their own experiences, but instead medical professionals were viewed as the authority:

“Yeah, I think, I think she believed it more ... when she met the psychiatrist and things like that ... I think she was more accepting about it then ... I guess ‘cos ... she probably trusted his professional opinion” (Lucy)

Some participants appeared to embrace a medical approach to understanding their experiences. For example, Trevor suggested that his diagnosis “*finally*” (Trevor) allowed him to understand his experiences, as if he had reached the end of the confusing sense making journey:

“I was diagnosed paranoid schizophrenic with delusions ... I finally had a diagnosis which was good ... because ... I just wanted to know what was going on with me” (Trevor)

However, other people, often who had spent a long time using mental health services, had appeared to lose faith in this medical approach due to professionals not appearing to understand their experiences or how difficult they can be:

*“I went to the doctor and he just said “can’t you just ignore them” and I said
“it’s not that simple”” (Daniel)*

This was the case for Fred, who appeared to be getting no benefit from the methods used to help him manage his experiences:

*“[They] just, give me loads of medication ... do you know when I was on 200
[Milligrams], 200 a week ... I was still getting the same symptoms. Even if they
give me 1000 [Milligrams] ... a week, I’d still hear them” (Fred)*

Fred appeared to be experiencing lots of frustration from the singular approach to his support, with his emphasis on “just” (Fred), as if this was the only option available, but was also entirely ineffective. Some participants rejected a medical understanding of their experiences:

*“No I don’t, I don’t think I see it as an illness ... I think of it as, I see myself as
having different experiences of the world” (Lucy)*

However, for Lucy, even when she did not take a medical understanding of her experiences, the people close to her still held those beliefs. Lucy appeared to feel as if

her experiences were disregarded as illness, and the sometimes distressing reality of her experiences was not recognised:

“My partner kind of says “well ... yeah, that’s just part of the illness isn’t it” ... which kind of annoys me sometimes because it, it’s real to me so ... it annoys me that they’re saying it’s part of an illness” (Lucy)

Daniel, Fred, and Lucy all appeared to feel as if their experiences were not taken seriously, but instead were minimised and misunderstood, with phrases such as “*can’t you just ignore them*” (Daniel), “[*they*] *just give me load of medication*” (Fred), and “*that’s just part of the illness*” (Lucy) emphasising this process.

Superordinate Theme 2: Who can I talk to about this?

This superordinate theme recognises that, however participants had made sense of their experiences, most reported fear, shame, and/or distress associated with their voice hearing. This appeared to be for many different reasons, though largely related to how they believed other people might respond or view them if they knew about their voice hearing experiences. Because of this, participants were not entirely open with everyone about their experiences and managed how they discussed them with different people.

Subordinate Theme 2.1: They’ll think I’m a monster

This subordinate theme explores how participants often concealed both that they heard voices, and the content of their voices, in order to manage feelings of fear and shame associated with them.

The vast majority of participants spoke about how they tried to hide their voices from other people. Some, such as Janet, appeared to be very frightened of how her loved ones might think of her if they knew that she was hearing voices. Because of this she tried to keep this a secret, despite this being very difficult due to the distress associated with the experience. Note her use of “*as much as I could*” (Janet) and “*I couldn’t hide it anymore*” (Janet):

“I hid it as much as I could from other people ‘cos I didn’t want them thinking ... you know you think what they’re gonna think of me do you know? ... and I hid a lot of it until it become point, to the point where I couldn’t hide it anymore”
(Janet)

This appeared to suggest an internal conflict where there was a desire to discuss the experiences, but a fear of what may happen with openness. Trevor appeared to go through a similar process, where he felt he had to keep his experiences to himself so that he wasn’t taken away from society or rejected by his family. He appears to have used the word “*but*” (Trevor) to emphasise this conflict:

“I was seeing things, I was hearing things, but I kept it all to myself ... ‘cos I was frightened of being sectioned off” (Trevor)

“I mean...if my dad was to know that I was suffering from schizophrenia...he’d disown me” (Trevor)

For other participants, the secrecy was not just about being a person who hears voices and the negative things that may come from others' awareness of that, but also about what the voices said. For Daniel, talking about his experiences of voice hearing was difficult because the voices said things that could appear controversial and distressing:

“The first question they asked you, if you say you’re hearing voices, what do they say?” ... it’s quite hard to tell him that, when they’re so negative and that lot ... I mean, to be called a puff and pervert and a paedophile ... [PAUSE] ... it’s quite shocking isn’t it?” (Daniel)

This appeared to be associated with a fear that others may believe what the voices say is true. He reported keeping the details of what his voices say secretive from family members. When asked how he imagines family members may respond if he was open about the details, he said:

“I don’t think they’d ... look at it too nicely ... [PAUSE] ... they’d, they’d think I was a monster or something like that ... so, I pull punches really, you know what I mean ... when it comes to family and that lot” (Daniel)

Like other participants, Daniel appears to suggest that he would like to be able to talk more openly about his experiences, but feels frightened of how his loved ones may view him, so keeps secret for protection and to maintain positive relationships. For Fred, this even appeared to be the case in the research interview; where he began to disclose what his voices say, then stopped mid-sentence:

“Some of the stuff it says ... some of the stuff it says. They say ... [LONG PAUSE] ... no ... [LONG PAUSE] ...” (Fred)

Subordinate Theme 2.2: I only really talk to my nurse or consultant

This subordinate theme describes how participants often spoke only to people who were thought to be experts on voice hearing experiences, either due to professional status or through personal experience, as they were concerned that other people would be more concerned and less understanding about their experiences.

Many participants reported a preference to talk primarily to mental health professionals or people with knowledge of mental health. For Janet and Fred, this appeared to be because they were concerned that talking about their experiences would upset or worry family members:

“It’s easier to talk to people who aren’t ... emotionally involved with you, because ... you don’t have to worry about upsetting them ... whereas I always worry ... about my partner and my children” (Janet)

“The only people I really talk to is my CPN and my ... consultant” (Fred)

Talking to professionals who were not *“emotionally involved” (Janet)* therefore allowed more open discussions without risking damage to more intimate relationships. Notice Fred’s use of *“really talk” (Fred)*, as if to say he has to talk superficially when talking to loved ones. Related to this was an expectation from some participants that

family who work in health or care settings would be more accepting or understanding, so that they were less anxious about disclosing experiences:

“I’ve told me mam. Yeah, my mum’s a nurse ... she worked at the [LOCAL HOSPITAL] ... in the high dependency ward ... so...she’s come in contact with people with mental illness god knows how many times” (Trevor)

Daniel appeared to feel safest talking to other people who had heard voices so could personally relate to the experiences, in comparison to family members who may be less understanding. His use of the phrase *“I can talk” (Daniel)* may suggest that he feels as though he cannot talk about these experiences in the same way to most people:

“I can talk to my mate about voices ... ‘cos he’s got a similar illness and he hears things as well ... I can tell him things and, err, he can relate to them ... and he can tell me what he thinks his explanation of it is” (Daniel)

Subordinate Theme 2.3: I’ve been careful when talking about it

This subordinate theme explains how participants would often take caution and consideration when discussing their voice hearing experiences, with the aim of disclosing information while also managing any negative perceptions and concerns of other people.

It was not always possible, nor desirable, for participants to keep their experiences of voice hearing secret from family and friends. However, when people did talk to their family and loved ones about their experiences, they often did so with great

caution. For example, multiple participants discussed how they would talk superficially about their experiences, rather than engage with in-depth disclosures. Notice the use of the word “just”, in phrases such as “*we just talk about*” (Lucy), “*I just say*” (Fred), and “*I just said*” (Daniel) which appeared to suggest that they were not being, or couldn’t be, fully open and honest:

“I still don’t talk specifically about certain, like, hearing things or anything like that, we just talk about the general kind of “oh, how are you feeling” sort of thing ... I still don’t feel comfortable telling her, like “oh, yeah, I’ve been hearing things” or things like that, or like “something’s gone on”, I don’t feel comfortable about that ... I think ... it just got easier to talk to her about generic things” (Lucy)

“They know I hear voices ... they just say “how’s your mental health” and I just say “it’s good”, “it’s moderate”, or “it’s ... rubbish”” (Fred)

“I just said to her “it’s probably my illness that’s causing it, for me to have these delusional thoughts and that lot” ... I said “don’t think that much about it” and that’s about as much as I talk to my daughter about it” (Daniel)

This may again reflect a fear of how family and friends might respond or view the person if they knew the full details of their voice hearing experiences, in addition to any shame experienced in relation to the upsetting content of the voices. For Fred and Daniel, talking broadly about “*mental health*” (Fred) or “*my illness*” (Daniel), meant

that they did not need to go into detail about their experiences, as their experiences were accepted to be symptoms of an illness so needed no further explanation.

Lucy however reported viewing voice hearing as *“having different experiences of the world”* (Lucy) rather than as illness, so could not fall back on these explanations. However, she still managed how she spoke about her experiences, with the aim of reducing any concerns or worries others may have about her or her experiences:

“It’s best to kind of ... tell them ... after it’s happened ... rather than at the time ... ‘cos then I can say “look, this happened, but I’m alright now”” (Lucy)

“I’ve kind of been careful about it ... and just said little things ... like if I’d ... seen something or heard something” (Lucy)

“If I’ve heard something or seen something ... I’ll kind of ... just make a joke about it, be light hearted about it, rather than be real serious about it ... and I think people tend to react better to it ... when you do that” (Lucy)

Together, Lucy’s techniques to manage how she disclosed her experiences seemed to be a way to assure people that she was not “ill”, while still being able to talk about and make sense of her confusing experiences.

Superordinate Theme 3: I was shocked by how they responded

This superordinate theme focusses on how participants experienced other people’s responses to their disclosures of voice hearing. Family and friends responses to

disclosures appeared very important, influential, and often shocking to participants. Most participants had disclosed that they had heard voices, whether intentionally or accidentally, to family members, their partner, and sometimes to friends.

Subordinate Theme 3.1: They kind of freaked out

This subordinate theme explains how others' responses to disclosures were often very upsetting for the person who heard voices, leading to an increase in the feelings of shame and the secrecy highlighted in Superordinate Theme 2.

The vast majority of participants reported difficult experiences of disclosing their voice hearing experiences. Participants' family members and partners often responded with panic and distress, which could lead the participant to feeling upset and ashamed:

“They kind of freaked out a little bit ... I was with this ... team at the time ... they went to speak to someone ... and basically demanded that they tell them what was going on with me and things like that ... and it just got a bit out of hand really ... it escalated quite quickly” (Lucy)

For Lucy, her family's reaction to her disclosure appeared to suggest there was something seriously wrong. By approaching the mental health team as the authority on her experiences the reaction also appeared to undermine Lucy's own ability to report and understand her experiences.

For multiple participants, their feelings of shame and fear appeared to be reinforced by talking to their family. Janet and Lucy believed their family felt that their

experiences brought shame to the family as a whole; so that it was not always possible to be open, but instead it was necessary to play a role and keep secret.

“I think family have responded the worst ... because I think it’s like, they think ... it’s a stigma, do you know, if it affects me then it, it focusses, it focusses on them” (Janet)

“I think as long as ... I look okay, they’re okay, but when things start to go a bit downhill they don’t like it ... [PAUSE] ... I think they kind of like to try and play happy families ... rather than accepting that there is something wrong” (Lucy)

Some participants were met with disbelief when they disclosed their experiences, which may have further reflected family members’ fears and shame of having a person who hears voices within the family:

“I told me mam what I was talking to her ... the lady who was there and what have you ... and my mum turned round and says “oh no, you’re dreaming” you know “it’s, you’re just having, erm, nightmares, don’t worry about it” ... and it was kind of swept under the carpet” (Trevor)

“I don’t think they quite believed me at first ... I think they thought I was just making it up” (Lucy)

For Janet, the shame and fear of her family appeared so great that they stopped communicating with her all together, seemingly rejecting her from the family:

“I’ve lost quite a lot of people because of it ... I just don’t think they understand ... I think it’s ... they’re frightened so they just walked away” (Janet)

Janet appeared to struggle with this, both because of the loss of her loved ones, but also because of what this suggested about her; notice her use of *“I think” (Janet)* and *“I just don’t think” (Janet)* as she attempts to understand this distressing experience. Janet may have taken this to mean that she is dangerous or damaging to the family, perhaps reflecting stigma around her experiences.

Subordinate Theme 3.2: They were really calm and talked it through with me

This subordinate theme highlights how participants were positively surprised by some responses to their disclosures; which appeared to support the sense making process highlighted in Superordinate Theme 1 and reduced the feelings of shame discussed in Superordinate Theme 2.

Some participants spoke about more positive responses to disclosing their voice hearing experiences. Participants appear to particularly appreciate when the people disclosed to did not panic or get upset:

“He was really good about it to be honest ... I think he was slightly shocked ... but ... he just took it in his stride ... he’s really calm” (Lucy)

“It just didn’t faze her what, whatsoever ... it really didn’t ... and she said “just know, whatever you choose I’m here”, do you know ... “I’ll always be here” she said, “I aren’t going nowhere” ... It’s just absolutely amazing” (Janet)

For Janet in particular, this seemed especially important, as it was an indicator that she would not be abandoned and would be supported through her struggles. These responses also surprised participants, as they appeared to expect negative responses from other people; possibly as a consequence of distressing previous disclosures. Notice the use of *“to be honest” (Lucy)* and *“it really didn’t” (Janet)*, which emphasised their surprise at the calmer responses. These responses appeared to reduce some of the shame and fear participants had experienced.

Calmer responses to disclosure appeared to allow two other processes to take place. The first was support with problem solving or practical solutions, which encouraged “normality”, and did not encourage a person to think they were abnormal and couldn’t be supported:

“He’s always like “sit down, just sit down, we’ll talk about it” do you know ... “talk about whatever is bothering you, or do you want to go for, or we could go for a drive, we can take the dog for a walk” ... he’s just amazing, and he’ll sit and talk, he’ll sit and talk to me” (Janet)

“I can always go and talk to me mam, she’s, she’s great is me mam, real nice lady... if I’ve got a problem she’ll still, still sit there and have a talk with me and have a cup of coffee” (Trevor)

Calmer responses also encouraged participants to be more open and comfortable discussing their experiences, which appeared to reduce the feelings of stigma and supported the aforementioned sense making process:

“It’s been nice to talk, to talk about it to be honest with you ... ‘cos, like I say, there’s, it’s a bit, it’s still seen as a bit of a taboo” (Trevor)

“But it’s helped to actually help put it into concepts of how it all works out and that lot” (Daniel)

Again, phrases such as *“to be honest with you” (Trevor)* and *“actually” (Daniel)*, appear to suggest a sense of surprise that calm conversation had been a way to understand experiences and reduce feelings of shame and fear.

Discussion

The aim of this research was to gain a deeper understanding of what it is like talking about voice hearing with family members, friends, and others. The research has provided evidence that interactions with important others can have a major impact on many aspects of an individual’s experience of hearing voices. Many of the themes developed through the research appear to complement the previous qualitative research of Romme and Escher (1989) and Holt and Tickle (2015) where it is clear that individuals who hear voices experience stress and confusion when attempting to understand their experiences, and few have singular understandings of their experiences.

The present research similarly appears to support the idea that interactions with other people contribute towards this sense making process. One theme that appears to have expanded on the sense making literature is “I was hearing things they couldn’t”, which recognised that before attempting to understand the nature of their experiences, participants had to recognise that there was a difference between what they could hear and what others reported hearing. How people made sense of this could then lead to the development of more complex understandings of why they heard voices. This also meant that, perhaps unlike other stigmatised groups, people who hear voices may not always be aware of their disclosing, meaning it is less possible to manage how one wishes to disclose.

As reported in Holt and Tickle (2015), people who hear voices frequently have a desire to discuss and understand their experiences, but can experience a range of factors which disrupt this. In their research, it was suggested that a fear of being “mad” or having particularly distressing or powerful voices were major blocks in the sense making process. In the present research the experience of shame was highlighted; not just as a barrier to the sense making process, but as a barrier to positive relationships generally. Participants described multiple areas associated with shame; including shame about being a person who hears voices, shame about the content of voices, and feeling as if they brought shame to their families. This suggested that participants and the people close to them appeared to view their experiences (and themselves by extension) as abnormal, wrong, bad, or unacceptable. This may reflect stigmatising societal views of voice hearing experiences, which associate voice hearing with violence, “madness”, and suicide (Vilhauer, 2015; Holt & Tickle, 2015; Knight, et al., 2009; Mawson, et al., 2011). Techniques used in mental health services which aim to rid people from the

experiences of voice hearing may also reinforce this by passively suggesting the experiences are abnormal and should not be experienced (British Psychological Society, 2014).

Many participants experienced reactions to disclosing their voice hearing which were distressing, for both the individual and the people disclosed to. This research begins to recognise the wider impact voice hearing can have on families, where concerns about stigma (and associated shame) can spread throughout the family. This at times led to abandonment and other distressing outcomes for the individuals who hear voices; which would very likely impact upon their psychological wellbeing. Furthermore, some families actively encouraged secrecy about voice hearing experiences, in direct contrast with recent literature which recognises that talking openly about the relationships with (and meaning of) voices can lead to positive therapeutic outcomes (British Psychological Society, 2014). These conclusions are also similar to those drawn from literature around “expressed emotion” (Amaresha & Venkatasubramanian, 2012; Butzlaff & Hooley, 1998), where the more emotionally expressive responses were often more distressing for the discloser. Perhaps not recognised in previous literature is how important the more positive reactions to disclosure can be to an individual’s wellbeing. Calm and open responses to disclosures appeared to promote the sense making process for many participants in this research and supported the use of problem solving and coping strategies.

Across all the research themes was a reoccurring idea that open, supportive, and trusting relationships were incredibly important. Relationships of this nature with family, friends, and others supported the sense making process, helped reduce fear and shame, and encouraged the person to feel safe and secure in their relationships. The

philosophy of the Open Dialogue Approach to mental health care directly works with these ideas (Open Dialogue UK, 2017; Seikkula & Olson, 2003; Seikkula, et al., 2003; Seikkula, et al., 2004). Open Dialogue is an approach to mental health services which developed in Western Lapland, Finland, in the 1980s. Prior to the development of this way of working, Western Lapland reported some of the highest rates of Schizophrenia, a diagnosis frequently associated with voice hearing, in Europe. However, since the development of the Open Dialogue approach these rates have reduced dramatically, with major improvements in the amount of people returning to work or education after experiencing crises associated with voice hearing or other experiences which can be confusing and distressing (Open Dialogue UK, 2017; Seikkula & Olson, 2003; Seikkula, et al., 2003; Seikkula, et al., 2004).

In many parts of the Western world (including Western Lapland prior to the introduction of the Open Dialogue Approach) when an individual first experiences voice hearing or other confusing experiences, the individual is encouraged to speak to medical and/or mental health professionals in order to provide an explanation and offer a solution to their struggles, such as antipsychotic medications. However, rather than requiring an individual to seek expert opinion, the Open Dialogue Approach recognises the importance of an individual's immediate relationships and encourages the use of open discussions within the family network to support an individual through mental health crises. During these stressful time periods, family members (including the individual experiencing voice hearing) are encouraged to communicate, tolerating the emotions and uncertainty in the situation, in order to develop a shared and co-constructed understanding of the experiences. Included in this is the recognition that sense making will take place very quickly as an individual begins to experiences voice

hearing or similar experiences, so that the open conversations need to take place very quickly. The approach is finding increasing empirical support and is now being integrated into mental health services in parts of the UK (Open Dialogue UK, 2017; Seikkula & Olson, 2003; Seikkula, et al., 2003; Seikkula, et al., 2004). The present research supports many of the values of the Open Dialogue Approach, recognising that open conversations and tolerance of distressing emotions can support an individual to make sense of, and better manage, their experiences of voice hearing in a social world.

Methodological Limitations

A small homogenous sample of participants was recruited for the research, in line with IPA methodology (Smith, et al., 2009). Had participants been from different locations or populations then different conclusions may have been drawn. Similarly, individuals recruited outside of mental health services may have had different experiences, perhaps with less of a focus on a medical understanding of voice hearing. Any generalisation of the research conclusions therefore needs caution.

Given the interpretative nature of the research, it is also expected that the researcher's values, beliefs, and experiences will have had an influence on the research process. Though the researcher has aimed to be as transparent as possible by outlining their position, caution should still be taken when attempting to apply the interpretation more broadly.

Future Research

Further research could enquire into the experiences of people who hear voices but do not access mental health services. It may be expected that these individuals make sense

of their experiences in different ways to those accessing mental health services. For example, if family and loved ones are either very supportive or very critical, an individual may not feel they need to access mental health services or may not feel comfortable doing so. Alternatively, future research could enquire about the experiences of people who have been disclosed to, rather than the discloser themselves. This may further contribute to a more social understanding of voice hearing experiences.

Clinical Implications

There are three inseparable areas of clinical consideration which can be highlighted from the research findings, pertaining to: 1) relationships, 2) sense making, and 3) managing shame and stigma. For the first area, relationships, this research has emphasised how trusting, curious, and non-judgemental relationships are a fundamental part of how people who hear voices understand what is real and what is not, make sense of their voice hearing experiences, and manage the shame associated with the experiences. Anyone, mental health services included, who wishes to support individuals who hear voices, should aim to be mindful of the quality of the relationships these people experience. In cases where people who hear voices experience positive and supportive relationships, particularly from family and loved ones, these relationships will be a key source of help and support for the individual to understand their experiences, manage shame and stigma, and overcome difficulties in day-to-day life. However, there may be some situations where individuals who hear voices may have people around them who hold stigmatising views, experience family shame due to personal views about voice hearing, or respond to disclosures with panic and distress. In these cases services should aim to support the whole family and/or may wish to support

the individuals in accessing other more supportive relationships. This may include incorporating ideas associated with the discussed Open Dialogue Approach (Open Dialogue UK, 2017; Seikkula & Olson, 2003; Seikkula, et al., 2003; Seikkula, et al., 2004). Finally, mental health professionals should be conscious that they may be the only people an individual who hears voices trusts to discuss their experiences in a supportive and understanding way. They should therefore try to be aware of their large influence in how someone makes sense of their experiences, but may also wish to support individuals to speak to other trusted individuals, such as family and friends who could potentially offer further support, comfort, and advice.

For the second area, sense making, staff members and commissioners of services which support people who hear voices should consider the importance of sense making for this group; both in relation to people's realisation that others may not hear the same things they can and in relation to people's attempts to understand what they hear and why they hear it. As discussed above, this would likely be most powerful when supportive family, friends, and professionals are involved. The aim for professionals in supporting sense making would likely be similar whether support is directed towards the individual who hears voices alone or when including those around them. In particular it should involve openness to people's developing and changing understandings about voice hearing experiences, not undermining or closing down ideas, and recognition that people can hold many different views about the experiences. Similarly, professionals should be open to considering both the positives and negatives of a mental illness approach to voice hearing, recognising it as one way of viewing the experience which may support some and hinder others. This does not mean professionals should be silent about their own understandings of voice hearing, but

instead recognise their understanding as one of many potentially useful ways of making sense. Finally, it may be valuable for people who hear voices to be directed towards those with similar experiences, beliefs, and/or values in order to support the sense making process.

The third and final area of clinical consideration pertains to managing the shame and stigma associated with hearing voices in a social world. This research showed that, for some people who hear voices, disclosing these experiences (especially if unintentionally) can lead to negative outcomes, distress, and feelings of shame for the person. One way of reducing this could involve helping people to recognise when they are hearing voices as opposed to hearing things others can. This can perhaps be through exploration with trusted people (professionals or otherwise) who can help the person recognise similarities and differences between the voices and things others can also hear. As highlighted in the research, another way people manage the shame and stigma associated with voice hearing is to hide their experiences, either by being completely silent about them or talking in a more generalised and secretive way. Mental health services supporting people who hear voices should be aware that people will likely not be open about their experiences and may experience great shame talking about them. Discussing the experiences openly may be one way of reducing this distress. Education about common experiences for people who hear voices may also support this, by helping people to recognise that their experiences are shared by many people. Resources for example in the UK, such as those provided by the Mind charity, British Psychological Society, and the Hearing Voices Network, may support this (British Psychological Society, 2014; Corstens, et al., 2014; Mind, 2016). Finally, though there are some ways people who hear voices and those immediately supporting them can help

with shame and stigma, wider societal change is equally needed to destigmatise experiences and reduce negative and unhelpful stereotypes about people who hear voices. On an individual level this could mean questioning and calling out discriminatory and unhelpful attitudes and for mental health professionals this may mean questioning our current practice and considering alternatives to a purely medical and individualised understanding of voice hearing.

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Part Three: Appendices

Appendix A: Submission guidelines for *Clinical Psychology Review*

GUIDE FOR AUTHORS

DESCRIPTION

Clinical Psychology Review publishes substantive reviews of topics germane to **clinical psychology**. Papers cover diverse issues including: psychopathology, psychotherapy, behavior therapy, cognition and cognitive therapies, behavioral medicine, community mental health, assessment, and child development. Papers should be cutting edge and advance the science and/or practice of clinical psychology.

Reviews on other topics, such as psychophysiology, learning therapy, experimental psychopathology, and social psychology often appear if they have a clear relationship to research or practice in **clinical psychology**. Integrative literature reviews and summary reports of innovative ongoing clinical research programs are also sometimes published. Reports on individual research studies and theoretical treatises or clinical guides without an empirical base are not appropriate.

Submission

Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

PREPARATION

Peer review

This journal operates a single blind review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding acceptance or rejection of articles. The Editor's decision is final. [More information on types of peer review](#).

Use of word processing software

It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts,

superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the [Guide to Publishing with Elsevier](#)). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Article structure

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered.

Manuscripts should ordinarily not exceed 50 pages, *including* references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least through the prior calendar year) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (<http://www.prisma-statement.org/statement.htm>) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. **Note: The title page should be the first page of the manuscript document indicating**

the author's names and affiliations and the corresponding author's complete contact information.

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author within the cover letter.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address" (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract

A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

Graphical abstract

Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view [Example Graphical Abstracts](#) on our information site.

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Highlights

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). You can view [example Highlights](#) on our information site.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors can build footnotes into the text, and this feature may be used. Otherwise, please indicate the position of footnotes in the text and list the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

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- Make sure you use uniform lettering and sizing of your original artwork.
- Embed the used fonts if the application provides that option.
- Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Provide captions to illustrations separately.
- Size the illustrations close to the desired dimensions of the published version.
- Submit each illustration as a separate file.

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TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.

TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi.

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Please do not:

- Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
- Supply files that are too low in resolution;
- Submit graphics that are disproportionately large for the content.

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Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 1-4338-0559-6, copies of which may be ordered from <http://books.apa.org/books.cfm?id=4200067> or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK. Details concerning this referencing style can also be found at <http://humanities.byu.edu/linguistics/Henrichsen/APA/APA01.html>

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

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As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can

be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

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This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

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Reference to a book: Strunk, W., Jr., & White, E. B. (1979). *The elements of style*. (3rd ed.). New York: Macmillan, (Chapter 4).

Reference to a chapter in an edited book: Mettam, G. R., & Adams, L. B. (1994). How to prepare an electronic version of your article. In B.S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281-304). New York: E-Publishing Inc.

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Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the [research data](#) page.

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Interactive plots

This journal enables you to show an Interactive Plot with your article by simply submitting a data file. [Full instructions](#).

Appendix B: NICE quantitative quality checklist

Section 1: Population		
1.1 Is the source population or source area well described?	++ + - NR NA	Comments:
1.2 Is the eligible population or area representative of the source population or area?	++ + - NR NA	Comments:
1.3 Do the selected participants or areas represent the eligible population or area?	++ + - NR NA	Comments:
Section 2: Method of selection of exposure (or comparison) group		
2.1 Selection of exposure (and comparison) group. How was selection bias minimised?	++ + - NR NA	Comments:
2.2 Was the selection of explanatory variables based on a sound theoretical basis?	++ + - NR NA	Comments:
2.3 Was the contamination acceptably low?	++ + - NR NA	Comments:
2.4 How well were likely confounding factors identified and controlled?	++ + - NR	Comments:

	NA	
2.5 Is the setting applicable to the UK?	++ + - NR NA	Comments:
Section 3: Outcomes		
3.1 Were the outcome measures and procedures reliable?	++ + - NR NA	Comments:
3.2 Were the outcomes measures complete?	++ + - NR NA	Comments:
3.3 Were all the important outcomes assessed?	++ + - NR NA	Comments:
Section 4: Analysis		
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)?	++ + - NR NA	Comments:
4.2 Were multiple explanatory variables considered in the analysis?	++ + - NR NA	Comments:
Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)?	++ + - NR	Comments:

	NA	
5.2 Are the findings generalisable to the source population (i.e. externally valid?)	++ + - NR NA	Comments:

Appendix C: NICE qualitative quality checklist

Theoretical approach		
1. Is a qualitative approach appropriate?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do?	Clear Unclear Mixed	Comments:
Study design		
3. How defensible/rigorous is the research design/methodology?	Defensible Indefensible Not sure	Comments:
Data collection		
4. How well was the data collection carried out?	Appropriately Inappropriately Not sure/inadequately	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described?	Clearly described Unclear Not described	Comments:
6. Is the context clearly described?	Clear Unclear Not sure	Comments:
7. Were the methods reliable?	Reliable Unreliable Not sure	Comments:
Analysis		
8. Is the analysis sufficiently rigorous?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing?	Convincing	Comments:

	Not convincing Not sure	
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted?	++ + -	Comments:

Appendix D: MMAT quality checklist

Type of mixed methods study components or primary studies	Methodological quality criteria	Responses	
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?	Yes No Can't tell	Comments:
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?	Yes No Can't tell	Comments:
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?	Yes No Can't tell	Comments:
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?	Yes No Can't tell	Comments:
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?	Yes No Can't tell	Comments:
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?	Yes No Can't tell	Comments:
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?	Yes No Can't tell	Comments:
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?	Yes No Can't tell	Comments:

Appendix E: NICE quality checklist ratings for quantitative studies

Study	Checklist Item															
	1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	4.1	4.2	5.1	5.2	
Gurtman (1987)	++	-	-	+	++	++	+	+	++	++	++	+	++	++	+	
Jastrowski, Berlin, Sato, and Davies (2007)	++	+	+	-	+	+	-	+	+	++	++	++	+	+	+	
Scott, Caughlin, Donovan-Kicken, and Mikucki-Enyart (2013)	++	+	+	++	++	++	++	+	++	++	++	++	++	++	++	
Mendel, Kissling, Reichhart, Bühner, and Hamann (2015)	++	++	++	++	++	++	+	+	++	++	++	++	++	++	++	
Bos, Kanner, Muris, Janssen, and Mayer (2009)	++	++	++	++	++	++	++	+	++	++	++	++	++	++	++	
Pandya, Bresee, Duckworth, Gay, and Fitzpatrick (2011)	+	++	+	+	++	++	+	+	+	++	++	++	++	++	++	
Dowrick and Buchan (1995)	+	++	++	++	++	++	++	++	++	+	++	++	+	++	+	
Corrigan, et al. (2016)	++	+	++	++	++	++	+	+	++	++	++	++	++	++	+	
Burke, Wang, and Dovidio (2014)	++	++	++	+	++	++	+	+	++	++	++	++	++	++	++	
Percentage ++	78%	56%	56%	56%	89%	89%	33%	11%	78%	89%	100%	89%	78%	89%	56%	

Appendix F: NICE quality checklist ratings for qualitative studies

Study	Checklist Item														Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
Chen, Lai, and Yang (2013)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not sure/not reported	++
Martin (2010)	Not Sure	Clear	Indefensible	Appropriately	Unclear	Unclear	Unreliable	Not Rigorous	Poor	Not Sure/Not reported	Convincing	Relevant	Adequate	Not sure/not reported	+
Wood, Bolner, and Gauthier (2014)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Unclear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++

Appendix G: MMAT quality assessment ratings

Study	Checklist Item								Total
	1.1	1.2	1.3	1.4	3.1	3.2	3.3	3.4	
Gurtman (1987)	-	-	-	-	N	Y	Y	Y	75%
Jastrowski, Berlin, Sato, and Davies (2007)	-	-	-	-	N	Y	Y	Y	75%
Scott, Caughlin, Donovan-Kicken, and Mikucki-Enyart (2013)	-	-	-	-	Y	Y	Y	Y	100%
Mendel, Kissling, Reichhart, Bühner, and Hamann (2015)	-	-	-	-	Y	Y	Y	Y	100%
Bos, Kanner, Muris, Janssen, and Mayer (2009)	-	-	-	-	Y	Y	Y	Y	100%
Pandya, Bresee, Duckworth, Gay, and Fitzpatrick (2011)	-	-	-	-	N	Y	Y	Y	75%
Dowrick and Buchan (1995)	-	-	-	-	Y	Y	Y	N	75%
Corrigan, et al. (2016)	-	-	-	-	Y	Y	Y	Y	100%
Burke, Wang, and Dovidio (2014)	-	-	-	-	Y	Y	Y	Y	100%
Chen, Lai, and Yang (2013)	Y	Y	Y	Y	-	-	-	-	100%
Martin (2010)	Y	Y	N	N	-	-	-	-	50%
Wood, Bolner, and Gauthier (2014)	Y	Y	N	Y	-	-	-	-	75%
Percentage "Yes"	100%	100%	33%	67%	67%	100%	100%	89%	85%

Appendix H: Submission guidelines for *Journal of Clinical Psychology*

Journal of Clinical Psychology

Founded in 1945, the *Journal of Clinical Psychology* is a peer-reviewed forum devoted to research, assessment, and practice. Published eight times a year, the Journal includes research studies; articles on contemporary professional issues, single case research; brief reports (including dissertations in brief); notes from the field; and news and notes. In addition to papers on psychopathology, psychodiagnostics, and the psychotherapeutic process, the journal welcomes articles focusing on psychotherapy effectiveness research, psychological assessment and treatment matching, clinical outcomes, clinical health psychology, and behavioral medicine. From time to time, the Journal publishes Special Sections, featuring a selection of articles related to a single particularly timely or important theme; individuals interested in Guest Editing a Special Section are encouraged to contact the Editors.

Author Guidelines

Manuscript Preparation

Format . Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure Legends 9) Permissions. Start each element on a new page. Because the *Journal of Clinical Psychology* utilizes an anonymous peer-review process, authors' names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Style . Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, Sixth Edition*, available from the American Psychological Association, Washington, D.C. *Webster's New World Dictionary of American English, 3rd College Edition* , is the accepted source for spelling. Define unusual abbreviations at the first mention in the text. The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

Reference Style and EndNote . EndNote is a software product that we recommend to our journal authors to help simplify and streamline the research process. Using EndNote's bibliographic management tools, you can search bibliographic databases, build and organize your reference collection, and then instantly output your bibliography in any Wiley journal style. *Download Reference Style for this Journal:* If you already use EndNote, you can [download the reference style](#) for this journal. *How to Order:* To learn more about EndNote, or to purchase your own copy, [click here](#) . *Technical Support:* If you need assistance using EndNote, contact endnote@isiresearchsoft.com , or visit www.endnote.com/support .

Title Page . The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address (including e-mail address), telephone and telefax numbers of the author responsible for correspondence. Authors should also provide a short title of not more than 45 characters (including spaces), and five to ten key words, that will highlight the subject matter of the article. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Abstract. Abstracts are required for research articles, review articles, commentaries, and notes from the field. A structured abstract is required and should be 150 words or less. The headings that are required

are:

Objective(s): Succinctly state the reason, aims or hypotheses of the study.

Method (or Design): Describe the sample (including size, gender and average age), setting, and research design of the study.

Results: Succinctly report the results that pertain to the expressed objective(s).

Conclusions: State the important conclusions and implications of the findings.

In addition, for systematic reviews and meta-analyses the following headings can be used, Context; Objective; Methods (data sources, data extraction); Results; Conclusion. For Clinical reviews: Context; Methods (evidence acquisition); Results (evidence synthesis); Conclusion.

Permissions . Reproduction of an unaltered figure, table, or block of text from any non-federal government publication requires permission from the copyright holder. All direct quotations should have a source and page citation. Acknowledgment of source material cannot substitute for written permission. It is the author's responsibility to obtain such written permission from the owner of the rights to this material.

Final Revised Manuscript . A final version of your accepted manuscript should be submitted electronically, using the instructions for electronic submission detailed above.

Artwork Files . Figures should be provided in separate high-resolution EPS or TIFF files and should not be embedded in a Word document for best quality reproduction in the printed publication. Journal quality reproduction will require gray scale and color files at resolutions yielding approximately 300 ppi. Bitmapped line art should be submitted at resolutions yielding 600-1200 ppi. These resolutions refer to the output size of the file; if you anticipate that your images will be enlarged or reduced, resolutions should be adjusted accordingly. All print reproduction requires files for full-color images to be in a CMYK color space. If possible, ICC or ColorSync profiles of your output device should accompany all digital image submissions. All illustration files should be in TIFF or EPS (with preview) formats. Do not submit native application formats.

Software and Format . Microsoft Word is preferred, although manuscripts prepared with any other microcomputer word processor are acceptable. Refrain from complex formatting; the Publisher will style your manuscript according to the journal design specifications. Do not use desktop publishing software such as PageMaker or Quark XPress. If you prepared your manuscript with one of these programs, export the text to a word processing format. Please make sure your word processing program's "fast save" feature is turned off. Please do not deliver files that contain hidden text: for example, do not use your word processor's automated features to create footnotes or reference lists.

Article Types

- **Research Articles** . Research articles may include quantitative or qualitative investigations, or single-case research. They should contain Introduction, Methods, Results, Discussion, and Conclusion sections conforming to standard scientific reporting style (where appropriate, Results and Discussion may be combined).
- **Review Articles** . Review articles should focus on the clinical implications of theoretical perspectives, diagnostic approaches, or innovative strategies for assessment or treatment. Articles should provide a critical review and interpretation of the literature. Although subdivisions (e.g.,

introduction, methods, results) are not required, the text should flow smoothly, and be divided logically by topical headings.

- **Commentaries** . Occasionally, the editor will invite one or more individuals to write a commentary on a research report.
- **Editorials** . Unsolicited editorials are also considered for publication.
- **Notes From the Field** . Notes From the Field offers a forum for brief descriptions of advances in clinical training; innovative treatment methods or community based initiatives; developments in service delivery; or the presentation of data from research projects which have progressed to a point where preliminary observations should be disseminated (e.g., pilot studies, significant findings in need of replication). Articles submitted for this section should be limited to a maximum of 10 manuscript pages, and contain logical topical subheadings.
- **News and Notes** . This section offers a vehicle for readers to stay abreast of major awards, grants, training initiatives; research projects; and conferences in clinical psychology. Items for this section should be summarized in 200 words or less. The Editors reserve the right to determine which News and Notes submissions are appropriate for inclusion in the journal.

Appendix I: Interview schedule

START OF INTERVIEW

In this interview I'd like to talk to you about the voices you hear and the experiences you've had related to them. In particular, I am interested in how you have found talking to others about your voices and what (if any) effect this has had on you.

Q1: Please could you tell me a little bit about the voices you hear?

Possible prompts: When did you first hear them? How did you feel about them? How did you make sense of why you were hearing them? What do you think about the voices? How many are there? Do you recognise them?

Q2: Who have you spoken to about your voices?

Prompts: Have you spoken to any loved ones, family, friends, colleagues, about your voices? Why did you speak to these people in particular?

Q3: How did you find talking to this person/these people about your voices?

Prompts: What was it like when you spoke to this person/these people about your voices? How did you feel talking to people about your voices?

Q4: How did the person/people you spoke to respond when you spoke to them about your voices?

Prompts: What did the person/people say when you told them? What emotions did the person display when you spoke to them about your voices?

Q5: Did anything happen as a result of talking to the person/people about your voices?

Prompts: What happened next? Did the person do anything different to usual after hearing the voices? Were you happy with what happened next or do you regret talking about the voices?

Q6: Overall, how would you describe the process of talking to others about your voices?

Prompts: Is there a build-up to talking about the voices? Is there a specific way of deciding who, where, and when to talk to?

If the participant does not talk about at least one in depth experience, but talks generally about their experiences, questions will be repeated in relation to a specific example. This will ensure that the desired rich and detailed information is acquired.

Thank you for talking to me about your experiences. Is there anything else you would like to add to what you have already said? Is there anything else you think we should talk about that has not been discussed so far?

END OF INTEVIEW

Appendix J: Participant Information Sheet

Date: 01/09/2016
Version Number: 1.3
IRAS ID: 201650

Humber 
NHS Foundation Trust

 UNIVERSITY OF Hull

Participant Information Sheet

Title of the study: The experience and effect of talking about hearing voices to close family, friends, and others.

You are invited to take part in a piece of research which aims to look at the experiences of people who have heard voices. More specifically around how people who hear voices have found the experience of talking about the voices they hear to people they consider close to them; such as family, friends, partner, or anyone else they feel fits this category. This information sheet provides the necessary information to consider for anyone willing to take part in the research. **The researcher will be happy to answer any questions you have.**

What is the purpose of the study?

There has as yet been very little research which attempts to ask directly about the experiences of people who hear voices, and no research at all around the effects of talking to others about hearing voices. It is hoped that through this research we are better able to understand these experiences, helping us to better understand and support people who hear voices.

Why have I been invited?

This information sheet is given to service-users who are attending Mental Health Services in Hull and East Riding, or are involved with the Hull or Goole Talking Heads Group, who may have experiences which fit the research area. Staff members at the service share the information sheet with anyone who fits the research criteria and who may be interested in participating for those involved in mental health services.

Do I have to take part?

NO. Participation in the research is **completely voluntary**. Deciding not to take part in the research for any reason will have no impact on your legal rights or the services you receive. If you decide to take part you will be **asked to sign a consent form** to show that you wish to take part. You are free to withdraw from the study **up until the point that the research results are analysed and written up** and you do not have to give a reason for this.

What will happen if I decide to take part?

If you agree to take part please complete the *contact details* section at the end of this information sheet and leave this with a member of staff. You will then be contacted by the researcher to arrange an appropriate time and place to meet. You will be asked to answer some short questions about yourself, such as your age and gender. A conversation will then take place between you and the researcher which will last **approximately 60 minutes**. The researcher is a trainee clinical psychologist and will be asking you about your experiences of talking about your voice hearing experiences. The **discussion will be audiotaped** to be used for the research. We are interested in your view, opinions, and experiences and there will be no right or wrong answers in the research. On completion of the interview a short

Date: 01/09/2016
Version Number: 1.3
IRAS ID: 201650

debriefing session will take place where you will have the opportunity to discuss your views, feelings, and experience of the interview. You will also be given a **Sources of Support** sheet which contains details of useful services in the local area. If you agree to take part you will be asked **if you wish to inform your GP** of your participation, which will be your choice.

What are the possible disadvantages and risks of taking part?

As participation in the study is expected to take approximately 60 minutes the inconvenience of this will likely be the main disadvantage. Additionally, given the nature of the research it is possible that **some people may experience emotional distress** when they talk about their experiences. If this happens the researcher **will offer you immediate support** and stop the interview if necessary. Furthermore, help will be given to access further support if needed. If there are any **significant disclosures of risk to the participant or anyone else**, then standard procedure would be followed to ensure the safety of the participant or anyone else.

What are the possible benefits of taking part?

It cannot be promised that there will be any direct and immediate benefits from taking part in the study. However, it is hoped that the information provided will help improve our understanding of the experience hearing voices, helping us to better support individuals and families with these experiences. Furthermore, participants of similar research have reported valuing having their views and experiences listened to and heard.

Where will the research take place?

The research interviews will take place at a **convenient time and location for participants** in the research. This can be within Mental Health Team premises, at Hearing Voices Group premises, or at a room in the University of Hull. The costs of travel **will not** be reimbursed.

What will happen if I decide I no longer wish to take part?

You are **free to withdraw from the study up to the point that the results are analysed and the study is written-up**. You are also not required to give a reason if you no longer wish to take part. Your legal rights or the support you receive from services will not be affected if you decide you no longer wish to take part.

What if there is a problem?

If you have any concerns or questions in relation to the study you can contact the researcher or their supervisor. They will do their best to answer any questions and resolve and concerns.

If you wish to complain about the research or anything related to the research please contact the Chief Investigator or either of the Academic Supervisors via the details provided at the end of this document.

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Will my taking part in this study be kept confidential?

YES. All the information that you provide will be kept **strictly confidential**. Any information that could be used to identify you will not be used in the research in any way.

The only occasion where information cannot be kept confidential would be if you disclose information which suggests **that you or someone else would be at risk of serious harm**. Should this happen the researcher will follow standard procedure, where appropriate authorities may be contacted in order to ensure that you and/or other people are safe. It is unlikely that this would happen and the researcher will try to discuss with you if concerns of this nature did arise.

All interviews will be digitally recorded on a Dictaphone. The recordings will be transferred to a **password encrypted memory stick** and deleted from the Dictaphone immediately following the interview. These recordings will then be transcribed verbatim on to a word document using **pseudonyms** (anonymous names) for any names disclosed during the interview. The word document will be stored on an encrypted memory stick and held by the Chief Investigator.

All identifiable data (such as names provided on consent forms) will be held separately from research data in order to protect anonymity. The identifiable data will be stored in a locked cabinet at the University of Hull by the Academic Supervisors. Research data will be held at the University of Hull by the Academic Supervisors for 10 years, in line with the standard procedure for University of Hull research.

What will happen to the results of the study?

On completion of the study you will be provided with written feedback of the results if you wish to hear them. The results will then be written up and submitted for publication to an academic journal. Some direct quotes from your interview may be used in the write up, however any personal details or identifiable data **will not** be included in the write up.

Who is organising and funding the research?

This research is being undertaken as **part of a doctoral research project in Clinical Psychology**. The research is funded and regulated through the University of Hull. Some relevant sections of data collected during the study which are relevant to taking part in this research may be looked at by the research supervisors from the University of Hull or from regulatory authorities to ensure that appropriate guidance was followed by the researcher.

Who has reviewed the study?

The study is reviewed by an independent organisation which is called a Research Ethics Committee. The Research Ethics Committee protects the interest of people who participate in research. This study has been reviewed by the North East - York Research Ethics Committee and has received a favourable opinion.

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If you have any further questions, comments, or queries, please don't hesitate to contact Simon Watkins. Thank you for taking the time to read this information.

Yours Sincerely,

Supervised by,

Simon Watkins
Trainee Clinical Psychologist

Dr Anjula Gupta and
Clinical Psychologist

Dr Chris Sanderson
Clinical Psychologist

Further information and contact details

Simon Watkins (Chief Investigator)

The Department of Clinical Psychology
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**Dr Anjula Gupta and Dr Chris Sanderson
(Research/Academic Supervisors)**

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a.gupta@hull.ac.uk
Email address (Dr Sanderson):
c.sanderson@hull.ac.uk

Date: 01/09/2016
Version Number: 1.3
IRAS ID: 201650

If you are interested in taking part in the study please leave your contact details in the space provided below. You will be contacted by the researcher to arrange a meeting at a convenient place and time.

Name:

.....

Address:

.....
.....
.....
.....

Telephone Number:

.....

Mobile Phone Number:

.....

Are there any times of the day that you prefer to be contacted?

.....

Do you have any further comments?

.....
.....

Signature:.....

Date:.....

Thank you very much for your interest!

Appendix K: Research Consent Form



CONSENT FORM

Title of Project: The experience and effect of talking about hearing voices to close family, friends, and others.

Name of Researcher: Simon Watkins, Trainee Clinical Psychologist

Please initial the boxes

1. I confirm that I have read and understand the information sheet **dated 01/09/2016 (Version 1.3)** for the above study. I have had the opportunity to consider the information. If I had any questions, they have been answered satisfactorily.

2. I understand that my participation is voluntary and that **I am free to withdraw at any time without giving any reason up to the point of data analysis and transcription**, without my medical care or legal rights being affected.

3. I confirm **that direct quotes from the interview may be used in future publications** and understand that they will be anonymised.

4. I understand that data collected during the study **may be looked at by individuals from regulatory authorities or from the NHS Trust**, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

5. I agree to take part in the interview part of the study and understand that my **interview will be audio taped**.

6. I understand that should any significant disclosures of harm to self or others be disclosed (past or present), as outlined in the information sheet **dated 01/09/2016 (Version 1.3)**, a standard procedure will be followed

7. I would like my **GP to be informed** of my participation in the study (Please circle yes or no),

YES / NO

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

When completed: 1 for participant and 1 for researcher site file

01/09/2016
Version 1.3
IRAS ID: 201650

Appendix L: Sources of support information sheet



08/04/2015
Version 1.1

Sources of support and information regarding voice hearing

Hearing Voices Movement (Talking Heads)
The **Hearing Voices Movement** is a support network for people who hear voices, see visions, or have other unusual perceptions. **Hearing Voices Groups** are set up around the country for people who hear voices to meet and discuss their experiences; named the **Talking Heads Groups** in Hull and Goole.

Hearing Voices Movement Website: <http://www.hearing-voices.org/>, or Google "hearing voices network"

Talking Heads (Hull): Contact Loraine Emery (Tel: 01482 389124), Anne Parry (Tel: 01482 335710) or Chris Sanderson (Tel: 01482 336778), **Website:** <http://www.humber.nhs.uk/services/talkingheads>

Talking Heads (Goole): Contact Lucy Holt, Steph Biddulph, or Sharonne Rennoldson, **Tel:** 01405 608 220, **Email:** talkingheads_goole@yahoo.co.uk, **Website:** <http://www.humber.nhs.uk/services/talkingheads>

Mental Health Services (Hull and East Riding)

If you are finding the experience of hearing voices distressing or having any other difficulties related to your mood it may be useful to contact **Mental Health Services**. Mental health services can be accessed via your **GP** who will refer you to the service they feel is most appropriate. You can also self-refer to some services. **Secondary Mental Health Services** assess your mental health and refer to the service most appropriate for your needs.

PSYPHER: An early intervention service which covers Hull and East Riding for people (aged 14 to 35) who have heard voices or had other experiences others may find unusual.
Tel: 01482 336786 (or contact your GP)

Secondary Mental Health Services in Hull: Tel: 01482 336161 (or contact your GP), Email: hmf-tr.smhs@nhs.net

The Single Point of Access (SPA) service for the East Riding:

Tel: 01482 301701, select Option 1 (or contact your GP), Email: HNF-TR.ERSPA-MentalHealth@nhs.net

The Samaritans

The **Samaritans** is a charity which offers support over the phone for anyone facing emotional distress. Their role is not to offer guidance or advice but simply to listen to anything a person wishes to talk about.

Samaritans (National): Tel: 116 123 (this number is free to call), Email: jo@samaritans.org

Website: <http://www.samaritans.org/>

Samaritans (Hull): Tel: 01482 323456 (local call charges apply)

Mind

Mind is a charity which provides advice and support to empower anyone experiencing a mental health problem. They campaign to improve services, raise awareness, and promote understanding.

Mind (National) Website: <http://www.mind.org.uk/>

Mind (Hull and East Yorkshire): Tel: 01482 240200, Info Line: 01482 240133, Email: info@mindhey.co.uk, Website: <http://www.mindhey.co.uk/>

Thank you for taking part in the study!

Appendix M: Example of data analysis

Ideas for themes	<u>Participant Transcript</u>	Notes
<p>Others can be “funny” about voices</p> <p>Voice hearing <i>not</i> as identity</p>	<p>P: Erm... [PAUSE] ...<u>I sometimes speak to my partner, my boyfriend...</u></p> <p>S: Okay</p> <p>P: ...erm... [PAUSE] ...<u>I haven't spoken that much to my parents...</u></p> <p>S: Right</p> <p>P: ...'cos they're a bit funny about stuff like that...</p> <p>S: Okay</p> <p>P: ...but <u>I speak to my partner, my boyfriend...</u> but <u>to be honest, I don't really consider myself to be someone who “hears voices”...</u></p> <p>S: Oh right, sorry...</p> <p>P: ...<u>if that makes sense...</u></p> <p>S: Yeah</p> <p>P: ...so...erm...<u>I, I don't, I, I know I have done but I, I don't think, I don't put myself in that kind of bracket...</u></p> <p>S: Yeah</p> <p>P: ...erm...<u>I don't, I don't know why, I just don't.</u></p> <p>S: No</p> <p>P: No</p> <p>S: That's fair...but am I alright to ask how you would describe it,</p>	<p>“sometimes”, not always? Partner is first person thought about? Suggestion that partners and family are most appropriate to talk to?</p> <p>Spoken less about voices with parents. Suggestion that could have done?</p> <p>Doesn't like to speak to parents because they're “funny” about it.</p> <p>Speaks more with boyfriend than parents. Doesn't consider herself to be someone who hears voices. Is that a specific type of person? Voice hearer as identity?</p> <p>Voice hearing not defining part of her? Voices not important to her? Bracket, voice hearer as type of person/stereotype?</p> <p>Unsure why she's not a voice hearer? Not about hearing voices or not, about a type of person?</p>

<p>Voice hearing not identity</p>	<p>if...instead? P: Yeah...erm... [LONG PAUSE] ...I kind of...I don't know if <u>it's like denial, that I don't think it happens, even though I know it has happened, I don't really accept that it has.</u> S: Right P: I'm not sure why [SAID VERY QUICKLY]. S: Fair P: [LAUGHS] S: Okay...am I okay to ask what your...erm, when you first, maybe it was the partner, the first person you spoke to about it? P: Yeah, yeah</p>	<p>“denial” about having heard voices? About acceptance? Doesn't want to think she has heard voices.</p> <p>Doesn't want to explore some things?</p> <p>Laughs because doesn't want to explore things?</p>
<p>Anxiety about potential response to disclosure</p>	<p>S: Do you remember what that was like? P: Erm... [LONG PAUSE] ...I think I was a bit worried about <u>what he'd, he'd think...</u> S: Okay</p>	<p>Worried about what partner would think. Frightened of disclosing leading to bad things?</p>
<p>Positive experiences predict disclosure</p>	<p>P: ...erm...<u>but to be honest I'd, I'd had issues before that, so he kind of...he'd already been good about other things, so I assumed he'd be alright about this...</u> S: Oh, okay</p>	<p>Conflict between expecting negative responses and knowing usual response of partner. Previous positive experiences of disclosing unrelated things leading to positive appraisals of how disclosure may go</p>
<p>Trusted other for reality testing</p>	<p>P: ...erm...and I...<u>now I kind of use him to test out whether it's actually there or not...</u> S: Right P: ...so <u>like if I think I've hear something that I might not have, other people have heard, I'll ask him if he heard anything...</u> S: Yeah P: ...<u>just to kind of test it, so...</u></p>	<p>Partner used for testing whether voices are “actually there”. Testing out “reality” using others.</p> <p>Difficulty trusting own senses. Can be managed by having a trusting relationship? Partner used to test out if voice or something else.</p> <p>Partner used as a test, as aware her sense can be deceiving.</p>

<p>Anxiety about disclosing due to stigma</p>	<p>S: Ahh, yeah, that makes sense P: Yeah S: So you'll yeah, just check in... P: Yeah S: ...see if he's heard the same thing. P: Yeah S: So, <u>when you first told him, you were a bit, you were a bit worried about how he might respond, but...</u> P: <u>Yeah, I was yeah...because obviously, it's a bit weird really [QUIETELY SAID]...</u> S: Right P: <u>...and there's quite a lot of stigma around stuff like that so...</u> S: Mmm P: <u>...yeah, I was a bit worried about it.</u> S: And, what did he, what did he say? P: <u>Erm... [LONG PAUSE, SURPRISED VOICE] ...he was really good about it to be honest, I, I don't, I think he was slightly shocked...</u> S: Right P: <u>...erm, but...he just took it in his stride, he didn't...he's...he's really calm...and he doesn't get ruffled by much so...</u> S: Okay P: <u>...I think that he, it was just his natural way of dealing with it...</u> S: Yeah P: <u>...he was just fine about it.</u> S: Ah, fair enough...and was that similar, different to how you</p>	<p>Anxiety about initial disclosures. Voice hearing viewed as weird. Whispering to keep it secret? Whispering because it's bad to call it weird?</p> <p>Worried about being open even with trusted people due to stigma associated with voices/"weird experiences".</p> <p>Great surprise that the response was "really good". Slightly shocked okay, big shock bad?</p> <p>"took it in his stride", didn't get overwhelmed/panic.</p> <p>His "natural way" was calm, didn't get "ruffled".</p> <p>Fine about it. Didn't stigmatise her.</p>
<p>Calmness of others helps with disclosure</p>	<p>S: Ahh, yeah, that makes sense P: Yeah S: So you'll yeah, just check in... P: Yeah S: ...see if he's heard the same thing. P: Yeah S: So, <u>when you first told him, you were a bit, you were a bit worried about how he might respond, but...</u> P: <u>Yeah, I was yeah...because obviously, it's a bit weird really [QUIETELY SAID]...</u> S: Right P: <u>...and there's quite a lot of stigma around stuff like that so...</u> S: Mmm P: <u>...yeah, I was a bit worried about it.</u> S: And, what did he, what did he say? P: <u>Erm... [LONG PAUSE, SURPRISED VOICE] ...he was really good about it to be honest, I, I don't, I think he was slightly shocked...</u> S: Right P: <u>...erm, but...he just took it in his stride, he didn't...he's...he's really calm...and he doesn't get ruffled by much so...</u> S: Okay P: <u>...I think that he, it was just his natural way of dealing with it...</u> S: Yeah P: <u>...he was just fine about it.</u> S: Ah, fair enough...and was that similar, different to how you</p>	<p>Anxiety about initial disclosures. Voice hearing viewed as weird. Whispering to keep it secret? Whispering because it's bad to call it weird?</p> <p>Worried about being open even with trusted people due to stigma associated with voices/"weird experiences".</p> <p>Great surprise that the response was "really good". Slightly shocked okay, big shock bad?</p> <p>"took it in his stride", didn't get overwhelmed/panic.</p> <p>His "natural way" was calm, didn't get "ruffled".</p> <p>Fine about it. Didn't stigmatise her.</p>

<p>Self-stigma, expecting negative responses and rejection</p>	<p>expected, or...? P: Erm... [LONG PAUSE] ...I think I expected a bit more of a <u>reaction [SOUNDS A LITTLE DISAPPOINTED]...erm...in terms of...I...think of it as being a bit more strange than he does...</u> S: Right [SURPRISED] P: <u>...I think he's more accepting of it... 'cos I think I have my own personal stigma towards it, so...</u> S: Right P: <u>...I think he's more accepting of it.</u></p>	<p>Expectation that others will view the experiences as strange/weird. Did little reaction mean she felt she wasn't understood/taken seriously?</p> <p>Partner more accepting of voices than she is. Can have personal stigma, so that non-stigmatising experiences are viewed as unusual. Shakes world view?</p>
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Appendix N: Ethical approval documentation from HRA and REC

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Appendix O: Epistemological statement

Pinning down an epistemological position for this thesis has been a difficult task, both due to the complexity of epistemology and the extent I believe I can hold a firm stance on the subject. However, for the purpose of this statement I believe some of the main ideas which contribute to the epistemological position of this portfolio are: positivism, social constructionism, and critical realism (Alvesson & Sköldbberg, 2009; Burr, 1995).

Given that clinical psychologists are trained as reflective *scientist* practitioners, a large part of psychology is an understanding of positivism and science. Positivism suggests that the universe is real, measurable, and can be understood through thorough examination using the scientific method; allowing the “truths” of a subject to be discovered (Alvesson & Sköldbberg, 2009; Denzin & Lincoln, 2011). To some extent ideas from positivism and science have been applied within this portfolio, where scientific literature has been examined in both the literature review and empirical paper. Specifically within the literature review, the scientific studies were examined for quality in terms of values of the scientific method in the quantitative checklist. Though positivism as an epistemological position offers some benefits, such as the ability to make useful predictions and compare large groups, it also comes with flaws. For example, the suggestion that we can measure objective truths through direct observation suggests that we could be perfectly objective machines, divorced from our experiences, culture, politics, wider social discourses, and power (Denzin & Lincoln, 2011).

Positivism is by no means the only position taken in this portfolio. Social Constructionism is an approach which suggests that rather than being found, like in positivism, knowledge is constructed through language and social interaction (Burr, 1995). Examples of where this has been relevant to this portfolio particularly relate to

how “voice hearing” is constructed in western society. As discussed in the empirical paper, voice hearing is often discussed in terms of mental illness in the western world. Attached to this are suggestions that people who hear voices are “detached from reality”, dangerous, and need to take medications. However, social constructionism allows us to consider whether this has to be the case. For example, in other parts of the world (including some culture in the UK) voice hearing is not understood as a sign of illness, but as a gift or power which is to be cherished (McCarthy-Jones, Waegeli, & Watkins, 2013). Social constructionism allows us to consider what our “lenses” may be, which could mean that experiences are viewed in a specific way, potentially allowing us to take a step back from these understandings and consider alternatives (Alvesson & Sköldbberg, 2009; Burr, 1995). For voice hearing, this may be that voice hearing is part of the natural variation of human experience, is a reaction to traumatic experiences, or many other different possible explanations (British Psychological Society, 2014). Social constructionism therefore accounts for some of the problems of a purely positivist epistemology, particularly recognising that knowledge can be constructed and not found. An entirely social constructionist epistemology however raises questions about ontology, particular relating to whether there really is any truth out there that we could find (realism) or if there is only that which is constructed (subjectivism) (Alvesson & Sköldbberg, 2009; Denzin & Lincoln, 2011).

Critical Realism is an approach which attempts to reconcile this conflict, with a suggestion of realist ontology alongside subjectivist epistemology; where there is a real existence out there, but the methods available to observe it are subjective, not objective, as suggested in a positivist approach (Alvesson & Sköldbberg, 2009). The knowledge of quantitative research and qualitative research are therefore both recognised as attempts

to make sense of reality, not thought to represent objective truths, but just our best attempts to understand (Alvesson & Sköldbberg, 2009). Therefore, this portfolio does not claim to represent objective facts or knowledge, but instead represents a subjective attempt to understand complex experiences through subjectivist methods developed for the purpose of answering specific questions.

References

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Appendix P: Reflective statement

I believe that I have learnt a lot from the thesis process, about myself, the area of study, about completing research, and many other areas. For the purpose of this statement I have focussed on a few areas of reflection that felt important to me: why I chose this topic, the interviewing process, experiences of interpretation, and the overall process of completing a thesis.

Why voice hearing?

Since I began studying psychology during my A-levels I was amazed by the subject's ability to understand complex and often very confusing experiences, with excitement about what new information I could learn about myself and others each lesson. One of the most notable was the recognition that through complex processes such as deindividuation and group thinking, humans could perform acts such as electrocuting strangers and even more horrific things such as murder. These areas of psychology were so valuable to me because they taught me two important things: 1) that anyone can be vulnerable to behaving in frightening and unacceptable ways given the right (or wrong) circumstances, and 2) that given enough thought, compassion, and consideration, even the most bizarre and frightening behaviours can be understood. Bad people were no longer bad and good people no longer good, but instead were an enmeshment of good and bad complexities and experiences.

I believe this interest in making sense of ideas and beliefs that many find confusing and "un-understandable" is one of the reasons I was drawn to studying voice hearing experiences. Before starting the course in clinical psychology I was aware of concepts such as "schizophrenia" which spoke about problems of a person's mind that

meant they would talk in disconnected ways, have “delusional beliefs”, and experience “hallucinations”. These ideas never fully made sense to me. Why did certain people develop these experiences and others didn’t? Who decided what was understandable and what was “word salad”? When does an uncommon belief become a “delusion”? Ideas discussed by critical psychologists helped me in similar way to my earlier A-level psychology classes. I recognised that people with these experiences do not have to be un-understandable and that they often experienced horrific things which may have led to them having peculiar experiences and developing different beliefs and ideas; they were not just “mad” as is often suggested in western society. I remember hoping that the process of interviewing people and making sense of their experiences would both help me better understand the experiences and could also help spread this knowledge if/when the work is published. My hope was that this could help “give a voice” to the people who are frequently misunderstood and help mental health services to better support people who may be struggling with their experiences.

The thesis journey

Though it may seem like a well-trodden cliché, the process of writing the thesis has been a journey, with all its trials and tribulations. Perhaps the first major hurdle I faced was deciding on research questions, both for the empirical and SLR. For both, the difficulty was never thinking of ideas, which I had in abundance, but choosing which idea to use. Thankfully my supervisors were able to provide advice and direction, reminding me to think of practicalities for the empirical paper, and helping me broaden my thoughts when initially searches were unfruitful for the SLR. Though never happy to have left so many avenues behind, I eventually settled on suitable questions.

The next trial, and possibly most frustrating, was the ethics application process. All this time had been spent developing ideas, preparing documents, and planning recruitment. I was not prepared for quite how confusing and tiresome the ethics process would then be. Changes in the process meant that neither I, nor the people who were assessing my application, properly knew what was needed. I was becoming disheartened after all the work up until this point, wondering why I had not heard from the ethics teams. However, I was waiting for no good reason and had actually received a relatively quick response, but was not aware. The replies had all gone to my junk folder on my email system. Now I was the one delaying the process! I quickly got in to gear, checking my junk folder obsessively, and after that the ethics process sped up greatly, and fortunately after a few back-and-forth corrections my study was approved.

This was a sudden shock. For months to years I had been planning and fighting to undertake this research, now I was let loose and had to actually do the research. Fortunately my supervisors had already been thinking about this again, and had in mind a base for my recruitment. Anne from the team I recruited from was amazing. Within weeks she had found multiple potential participants and after a few months we had recruited our participants.

Experiences of interviewing participants

Completing the research interviews felt like a whole new world to me. Of course I had completed interviews in my clinical work, but for the first time it was not necessary to hold any specific knowledge or to present as an informed professional. I was instead, similar to a journalist, a person who wanted to learn solely from the experience and expertise of the interviewee. Despite this, I remember feeling a pull to employ my

clinical training when interviewing the participants. This was particularly the case when at times participants asked my own view about something or appeared to be experiencing confusion or distress. I feel that remaining mindful of this helped to restrain from being pulled into helping.

Though it was possible to compare and contrast the participant interviews, the participants felt very different. The first interview I found surprisingly distressing, insightful, and inspiring. I remember feeling on the edge of tears when this participant spoke about how negatively people had responded to her disclosures and hearing about the struggles she had faced. I hadn't realised until listening back in the interview recording quite how I responded to this, noticing that I changed topics when some of the content was distressing. I believe this may have partly reflected an attempt to maintain the wellbeing of the participant, but also may have reflected my own experience of being overwhelmed. I found it valuable for my personal and clinical life to consider how I may respond to this type of situation. From this interview I also came to a revelation: the topic of the interview, talking about voice hearing, was being mirrored in vivo in interviews. Following the first interview I started to pay more attention to this, including asking more about how participants felt talking about their voices with me.

The third interview was perhaps the most surprising to me. This interview did not go at all as expected. The participant did not appear to wish to discuss his voice hearing experiences, instead telling me about his life history, his likes and dislikes, and many other topics. At the end of this interview the participant gave me a small gift after I had said I was unable to take his larger gift of a bottle of wine. I remember feeling confused and slightly frightened following the interview, feeling unsure of what happened, and struggling to understand the content discussed and the participant's

behaviour. Two revelations later struck me on gathering further information. A week after the interview I had met with the mental health team where I was recruiting in order to gather more participants. While at the service I was informed that the participant had spoken very highly of the interview, appearing to have reaped great benefit from the process. I felt both happy and confused about this. I am still uncertain what may have been useful for him. Perhaps it was simply the opportunity to talk about his experiences, perhaps it was piecing his experiences together, or perhaps it was just the company. I learnt from this, that however I make sense of an experience or feel about a discussion, another person may take something completely different away from the experience. The second revelation came when I listened back to the interview. Prior to this all I could remember about the interview was the peculiar discussions about the participant's favourite products and his previous accommodation. However, towards the end of the recording I heard the participant's disclosures of horrific experiences, where he had lost loved ones and been sent to an old fashioned psychiatric hospital. I am still not sure why I did not recall this, but was amazed that this happened. I wonder if it reflected his own processing of his experiences, where he appeared to keep the distressing aspects out of his mind most of the time.

The final interview provoked different emotions, such as guilt and sadness. The participant explained how little contact he had with people in his day-to-day life, but that interacting with other people helped calm his voice hearing experiences. He seemed so grateful to have had the opportunity to talk to me about his experiences, even though he appeared to find being open quite difficult. He often only answered with short sentences and stopped talking mid-sentence at times when we he was becoming more open about his voice hearing experiences. He explained to me that while talking to

people the voices remain quiet, but can get louder when people aren't around. He expressed anxiety and sadness towards the end of the interview when he realised he would be left with only the company of his voices. I was left with a drive to provide company and support, in the knowledge that without this, the participant's voices would continue to bother him. Fortunately, I was able to see the benefit of the debrief following the interview, where the participant asked if I could inform his care-coordinators about the interview, which would hopefully help them recognise the social aspects of his voice hearing experiences.

Experiences of interpretation

After such in depth interviews, where I felt I was given an insight into people's personal lives and experiences, it was really important for me that I did a good job with my interpretation and analysis. Before this, the closest I had done to an IPA style analysis was a thematic analysis, where I had to consider reoccurring themes in the data. I initially worked in a similar way for this research, with the aim of providing the "most accurate" understanding I could of the information participants had given me. Even at this point I struggled. I was hoping to complete this research largely to "give a voice" to the participants, but I was required to filter through interviews, collating the information I believed to be most important and representative. Who was I to make this decision? In order to manage this conflict I initially developed many themes, where I would include as many quotes as possible to represent them, feeling this would best capture *all* the experiences participants had described.

I quickly found this to be an impossible endeavour, with over 50 pages of potential themes. On reflection, I realised that I would not be able to convey any useful

information if I continued down this path. I also reflected on how, given the sparsity of research examining personal experiences of voice hearing, if I convey even a few pieces of valuable information I will have hopefully helped. Furthermore, the information which I conveyed had to be simple enough to grasp so that someone reading the final paper could at least begin to consider the personal experiences of people who hear voices. I therefore began to consider what could be the most important messages which I thought my participants would want me to convey.

Though I was then able to be more selective in which themes I chose to include and which quotes would best evidence them, something I was still not used to, or comfortable with, was interpreting the interviews. I was able to categorise and make sense of broader ideas in the data, but interpreting the data felt somewhat unfaithful to the participants, in addition to being “unscientific”. I was aware that IPA did not aim to be scientific but I was still cautious about adding myself to the research, likely as a remnant of the quantitative and positivist training from undergraduate psychology. However, at the recommendation of my supervisors I dove in and attempted the further analysis. I accepted as much as I could that I was not able to be objective in this work, so aimed to be open and transparent instead, so that people could consider my influence on the interpretation. I then felt a sense of freedom, as I was then able to reflect further on what my participants had to say. I felt I was able to better understand what my participants had to say by doing this and was able to make more sense of the data for myself. I now hope that the information participants gave to me, and the interpretation I offered, is able to add to the literature around voice hearing

The dreaded write up

The deadline for the initial SLR and empirical drafts snuck up so quickly. I was slowly getting on with my transcription and analysis when, during a thesis meeting in February 2017, it suddenly dawned on me how little time was left and how much I had left to do. I pressed on, working on evenings and weekends as often as I could. I still feel amazed that the work has eventually been completed, despite all the times it felt never ending. I am grateful that my supervisors supported me through this, providing both encouragement and critique even when I did not want to hear it. I am glad they were able to support me to keep working and keep motivated, and I hope all our hard work goes on to add to the important literature on voice hearing and mental health.