Mental health through a spiritual lens: recognising its role in psychological interventions and in how we make sense of our difficulties

being a Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology in the University of Hull

by

Sophie Lewis, BSc (hons) Psychology

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Dedication

This thesis is dedicated to Bill and Oonagh Collins, more affectionately known as Grandpa and Grandma; my pillars of strength, courage and compassion who, even in their absence, have been a continuous source of motivation.

Whenever I have wavered, I’ve taken strength in remembering who I started this for.
Acknowledgements

It is not conceivable to acknowledge all those that have been part of this journey with me; whether that is academically or emotionally. Though there are some that warrant explicit mention here. To my supervisors; the expertise, knowledge, and direction you have offered has helped to guide this project and my own chaotic thoughts into the piece of work it is today. However, your support extends beyond the academic realm. You have worked tirelessly to help maintain confidence in my abilities, and motivations to continue. This support has not gone unnoticed and I cannot thank you enough.

Without the participants who kindly volunteered their time to share their experiences, this research would simply not exist, so I would like to extend a special thanks to you. I complete this research feeling truly honoured that you shared your stories with me; I hope that you have been left feeling heard, understood and proud in the contributions that you have made. I hope I have been able to do them justice here.

Finally, to those closest to me. To my parents, for always inspiring me to be the best version of myself; for your unwavering love, support, and guidance as I have navigated the beginnings of my career with tears, tantrums and celebrations. I would not have found my way towards this research had you not always taught me to be who I want to be, regardless of popular opinion. To my brothers, for always keeping me down to earth and providing me with enough joy and laughter to see me through this process. To my dear friends who have stayed by my side even when I have been absent from their lives. Without your continued love, support and patience, my often necessary solitary confinement would have been far more stressful and lonely. And to my partner; for always lending me your ear, reminding me of the importance of self-care and compassion, allowing me space to work (that I often had to reluctantly accept), and trusting that I would return to normal after hand-in.

For Monty. My companion through it all.
Overview

This portfolio thesis has three parts. Part one comprises a systematic literature review, wherein the effectiveness of psychological interventions that integrate religion or spirituality are considered. Part two is an empirical research paper, wherein the role of spirituality is explored when individuals are making sense of hearing voices. Part three collates the appendices, containing supporting documentation and information for the systematic literature review and empirical research paper, as well as epistemological and reflective statements.

Total word count (excluding references and appendices): 17,923
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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
Towards spiritually or religiously informed interventions in mental health care:

A systematic literature review

Sophie Lewis*, Dr Chris Sandersona, Dr Anjula Guptaa

aSchool of Health and Social Work, University of Hull, Aire Building,
Cottingham Road, Hull, United Kingdom, HU6 7RX

*Corresponding Author. E-mail address: S.H.Lewis@2011.hull.ac.uk

Telephone number: +44 (0) 1482 464106

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Abstract

There have been well documented, historical biases against religion and spirituality within a clinical setting, particularly of a therapeutic nature. However, in recent decades there has been notable progress towards allowing the rhetoric of religion and spirituality within the therapy room, documented in its rise in inclusion and consideration in clinical practice. A systematic search of the literature was conducted to collate the available literature on the impact of a spiritual or religiously informed intervention, used with individuals experiencing a mental health difficulty. A total of eight quantitative studies were included for review and a narrative synthesis performed to establish methodological quality and the effectiveness of interventions. The results of this review suggest that utilising spiritually or religiously informed interventions for those with high value placed on their beliefs could be beneficial for reducing symptoms of mental health difficulties. However, further research would be beneficial within the realms of such adapted interventions, making particular use of religiosity and spirituality measures. This can not only provide more depth and evidence for the literature base, but it allows for better assessment and investigations into spiritually and religiously informed interventions.

Keywords


Introduction

Spiritual and religious beliefs are individual and subjective experiences. Whereas religious beliefs can be defined by the denomination an individual prescribes to, alongside organisational practice and a commitment to prescribed beliefs (Hodge & McGrew, 2006), spirituality is more amorphous. McCarthy-Jones, Woegli, and Watkins (2013) have found a recurring theme among spiritual definitions within the literature, wherein the majority relate to the meaning of life. For the purposes of this literature review, spirituality will be formally understood by the following definition: “an inner experience of connection to something greater than oneself, a personal state of the sacred and meaningful” (Lukoff, 2007, p. 635). Conflicting research exists regarding the interrelationship of these two constructs. Some research defines religion as incorporating spirituality (Tan & Dong, 2001), whereas in others spirituality is thought to incorporate religion (Walker, 2006). Other research has sought to identify a relationship between the two (e.g. Miller & Thoresen, 2003), rather than one encompassing the other. This lack of clarity and a unified understanding can lead to confusion within the body of literature. For the purposes of this review, a stance will be taken that there exists a relationship between the constructs. It should be noted, however, that the included papers may hold alternative views regarding their interrelation.

Historically, the relationship between spirituality, religious expression, and mental health has been fraught. Until the DSM-III (APA, 1980) spiritual and religious expressions were often pathologised or ignored when mentioned within a mental health context (Weaver, Samford, Larson, Lucas, Koenig, & Patrick, 1998). Such tension may have existed, and may still be present, due to the low numbers of mental health
professionals identifying as spiritual or religious when compared with the general population (Shafranske, 2000). Randal and Argyle (2005) noted that the foremost complaint of individuals accessing mental health services was that the spiritual side of their life was often pathologised or ignored; notably, the profession of psychiatry is highlighted as playing a significant role in this. This may have generated negative attitudes for religious individuals when considering psychological or psychiatric treatments, with the view that clinicians may be unsympathetic to the beliefs and values they hold (Weaver, 1995).

During the past few decades, however, new trends have emerged within clinical settings. Pargament (1997) noted that there exists considerable evidence for religion being a significant resource for individuals in times of distress, paving the way for further research to be conducted to ground this further within the psychological evidence base. Other researchers, practitioners, and scholars have endeavoured to bring religious and spiritual beliefs into the therapeutic room, and efforts have been made to allow access to perspectives and interventions informed by such beliefs (Post & Wade, 2009). This development in clinical practice could be accredited to research indicating a positive relationship between health, spirituality, and religion, as well as an increased encouragement of cultural diversity in practice (Hage, Hopsin, Siegel, Payton, & DeFanti, 2006).

Several reviews have been completed about the outcomes of spiritually oriented psychotherapy (e.g. Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis & McDaniel, 2011). All research concluded that such adaptations to traditional psychotherapies are effective within religious and spiritual populations (Richards,
This has provided clinicians with theoretical and clinical literature to support them in adapting their own practice effectively and ethically. Despite this, research on outcomes remains sparse and does not rival the quantity of literature focussed more generally within spirituality and mental health. Some authors have attempted to summarise and review outcomes studies though notably this has been done narratively (e.g. Oman & Thoresen, 2001; Worthington & Sandage, 2001). Although progress is being made, a growing literature base means a systematic review is beneficial. Systematic reviews collate the available literature on a topic and aim to evaluate and summarise their findings. Their strict scientific design increases reliability as others are able to replicate the literature search and synthesis, reducing biases and allowing critical analyses to be conducted.

The literature on the mediating impact of spirituality on mental health is complicated and often misunderstood, as there is no consistent definition or measurement of the construct (Koszycki, Raab, Aldosary, & Bradwejn, 2010). As is noted by Storch and colleagues (2004), the ability to form such truncated and measured assessment of an individual’s spirituality or religion is challenging due to the multidimensional nature of the constructs. Where researchers and scholars have assessed religion, this rarely expands beyond the variable of religious affiliation (Larson & Larson, 1994). This systematic literature review will help to collate and summarise these measures in a way that other reviews have failed to do so, allowing clinicians to utilise adapted therapies and effectively measure their efficacy.

The present review endeavours to collate the available literature that specifically investigates the effectiveness of a spiritual or religiously informed intervention, when
compared with traditional interventions or controls, in order to analyse and interpret the results. Part of this process will also be to systematically evaluate the quality of the identified literature. As will be discussed however, many of the studies included here have methodological weaknesses that means that interpretation should be cautious.

Review question

Are religious or spiritually informed interventions effective for individuals experiencing mental health difficulties?

Method

Search strategy

A systematic literature search was completed in March 2017. To ensure a comprehensive search of the available literature, the following databases were accessed via EBSCOhost: Cinahl, PsycInfo, PsycArticles, and Medline. Web of Science and PsycNet were also used. The following search terms were entered:

- spirit* OR relig* OR faith OR church OR mosque OR synagogue OR temple OR worship
- AND therap* or interv* OR psych*
- AND outcome OR effective* OR efficacy

The use of ‘spirit*’ and ‘relig*’ ensures that all terms containing ‘spirit’ (spirituality, spiritual etc), and ‘relig’ (religion, religious, religiosity etc) would be captured in the search. Words specifically associated with religion were also used (church, mosque, synagogue etc) to ensure that all papers pertaining to religion were adequately covered. The use of ‘therap*’, ‘interv*’, and ‘psych*’ ensures that all terms containing ‘therap’
(therapy, therapeutic etc), ‘interv’ (intervention, interventive etc), and ‘psych’
(psychological, psychology etc) were captured. This ensures that the articles returned
from the search pertain to mental health and intervention studies. In order to further
ensure that intervention studies were captured, the terms ‘outcome’, ‘effective*’
effective, effectiveness etc), and ‘efficacy’ were also used. Searches were then limited
to those fulfilling peer-review and that had been written in English. Date limiters were

Inclusion/Exclusion Criteria

In order to be included in the review the studies had to:

- Assess the impact of a spiritually or religiously informed intervention for those
  with mental health difficulties
- Include a measure of mood or psychological difficulty
- Include a measure of spirituality or religion, beyond demographic identification
- Include a control or comparison treatment group
- Make use of quantitative analysis only
- Be peer reviewed
- Be written in English

Duplicates were removed before the exclusion criteria were enforced at the stage of
abstract review.
Exclusion criteria

- Studies not written in English
- Single case studies
- Studies not using a measure of mental health or psychological difficulty or used general measures of well-being
- Studies not using a measure of spirituality or religion, beyond demographic identification
- Studies without a comparison or control group
- Studies using qualitative analysis, or mixed methods

No restriction was put on the age of the participants.

Article Selection Process

The initial Web of Science, PsycNET, and EBSCOHost searches produced 1288 results. Of these, the titles were screened for eligibility using the inclusion criteria outlined above. Of these, duplicates were removed and 69 articles had their abstracts reviewed. 12 articles were read in full, with 6 being rejected as they did not satisfy the inclusion and exclusion criteria. Reference lists were manually checked to ensure that no eligible articles were missed. Two further studies were accepted for inclusion in the review following a reference check. A final sample of 8 studies remained. Figure 1 offers a summary of how the above search protocol led to the final articles included for review.
Following this, a data extraction form was designed specifically for the purposes of the current review (see Appendix B), wherein the following broad focus points of information were extracted:

- Characteristics of participants
- Nature of the intervention
- Measures of spirituality and/or religion
- Findings relating to the efficacy of spiritually or religiously informed interventions

Figure 1. Article selection process.
Quality Assessment

The methodological qualities of the articles were assessed using the 19-item quality appraisal checklist devised by NICE (2012; see Appendix C). The checklist items are designed to assess the overall quality of each study as well as its methodology, results, and discussions. Quality is identified by a higher percentage of ++ ratings, indicating that the study has been conducted in such a way as to reduce the risk of bias. In order to ensure retention of reliability, the studies were rated against the checklist by both the research and an independent rater. The second rater, experienced in psychological research, cross-checked four (50%) of the included studies. There was overall agreement between the two raters; where any discrepancies arose the raters had a discussion to reach a consensus score. A summary of the final quality assessment scores can be found in Appendix D.

Data Synthesis

Though the studies being reviewed were deliberately quantitative in nature, a meta-analysis was not undertaken due to their heterogeneity. This was namely a result of the measurements used to assess the impact of the interventions, the variability in the definitions and measures of spirituality and religion used, alongside the primary mental health difficulty of the individuals. Thus, the findings of this review are presented following a narrative synthesis, summarised and explained through text, instead of statistics, allowing for an interpretive and reflexive account of the included literature (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005).

Results

Table 1 offers a summary of the main findings of the 8 studies included in the review.
Table 1. Summary of reviewed studies.

<table>
<thead>
<tr>
<th>Study (Author[s]; Year; Location)</th>
<th>Participant characteristics (sample size; clinical difficulty)</th>
<th>Intervention</th>
<th>Control/comparison group</th>
<th>Measurement of spirituality/religion (how/when?)</th>
<th>Measurement of mental health (how/when?)</th>
<th>Main findings</th>
<th>Quality rating (Percentage ++)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowland, Edmond, &amp; Fallot (2012)</td>
<td>N=43 Trauma</td>
<td>Spiritual intervention (group based on Trauma Recovery and Empowerment Model; TREM; Harris et al, 1998) N=21</td>
<td>Control N=22</td>
<td>Spiritual Assessment Inventory (Hall &amp; Edwards, 1996); Interpersonal Religious Discontent (subscale of RCOPE) Pre-intervention (T1); Post-intervention (T2);</td>
<td>GDS; PDS; BAI; PHQ-15; PRIME-MD Pre-intervention (T1); Post-intervention (T2); 3-month follow-up (T3)</td>
<td>Treatment group showed significant reductions across symptoms, with good maintenance at 3-month follow-up.</td>
<td>67%</td>
</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Condition 1</td>
<td>Condition 2</td>
<td>Measures</td>
<td>Results</td>
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<tr>
<td>Koenig, Pearce, Nelson, Shaw et al</td>
<td>132</td>
<td>Religious-CBT (Pearce et al, 2014)</td>
<td>Conventional CBT</td>
<td>Single items measuring importance of religion, religious</td>
<td>RCBT not superior to CBT on optimism, but both treatments increased optimism significantly.</td>
<td></td>
<td></td>
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</tbody>
</table>

3-month follow-up (T3)
<table>
<thead>
<tr>
<th>Koszycki, Raab, Aldosary, Bradwejn (2010; USA)</th>
<th>attendance, and private religious activity; multi-item measures of spiritual experiences (Underwood &amp; Teresi, 2002); intrinsic religiosity (Hoge, 1972)</th>
<th>Prior to commencement of intervention (T1); post-intervention (T2); 4-week follow-up (T3); 12-week follow-up (T4); 24-week follow-up (T5)</th>
<th>higher baseline religiosity may have affected the client sample.</th>
<th>No significant differences found between treatment groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Koszycki, Raab, Aldosary, Bradwejn (2010; USA)</strong></td>
<td><strong>N=22</strong> Generalised Anxiety Disorder (GAD)</td>
<td>Multifaith spiritually based intervention (SBI)</td>
<td>Cognitive behaviour therapy (CBT) <strong>N=11</strong></td>
<td>Duke Religion Index (Koenig, Parkerson, &amp; Meador, 1997)</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Interventions</td>
<td>Measures</td>
<td>Follow-up</td>
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<tr>
<td>Canada</td>
<td>N=11</td>
<td>Commencement of intervention (T1); Post-intervention (T2); 3-month follow-up (T3); 6-month follow-up (T4)</td>
<td>Effective treatment option, compared with CBT.</td>
<td></td>
</tr>
<tr>
<td>Pearce &amp; Koenig (2016; USA)</td>
<td>N=132</td>
<td>Major depression CBT N=65</td>
<td>NRC (subscale of BriefRCOPE; Pargament et al, 2011); BCOPE (Phillips et al, 2012); Single items measuring importance of religion, religious attendance, and private religious activity; multi-item MINI (Sheehan et al, 1998); BDI-II</td>
<td>Prior to commencement of intervention (T1); post-intervention (T2); 12-week follow-up (T3); 24-week</td>
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measures of spiritual experiences (Underwood & Teresi, 2002); intrinsic religiosity (Hoge, 1972)

Prior to commencement of intervention (T1); post-intervention (T2); 12-week follow-up (T3); 24-week follow-up (T4)

at baseline predicted a slower decline in major depressive disorder.

<table>
<thead>
<tr>
<th>Propst, Ostrom, Watkins, Dean, &amp;</th>
<th>N=59</th>
<th>Religious content CBT (RCT)</th>
<th>Standard CBT protocol (NRCT) N= 20</th>
<th>Types of religiosity (committed-consensual; Allen &amp; Spilka, 1967); Pre-</th>
<th>BDI; HRSD; GSI; SAS</th>
<th>Significant decrease in post treatment depression to 48%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Intervention</td>
<td>Measure</td>
<td>Follow-up</td>
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<tr>
<td>Mashburn (1992; USA)</td>
<td>N=19</td>
<td>Pastoral counselling</td>
<td>intrinsic-extrinsic (Allport, 1966); measure of religious experience (King &amp; Hunt, 1972)</td>
<td>intervention (T1); Post-intervention (T2); 3-month follow-up (T3); 24-month follow-up (T4)</td>
<td></td>
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<tr>
<td>Richards, Berrett, Hardman, &amp; Eggett (2006; USA)</td>
<td>N=122</td>
<td>Spirituality group</td>
<td>RWB; EWB; SWBS (Ellison &amp; Smith, 1991)</td>
<td>Spirituality group score significantly lower on psychological disturbance and higher on spiritual wellbeing at conclusion of treatment.</td>
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<tr>
<td></td>
<td></td>
<td>Cognitive group</td>
<td>EAT; BSQ; MSEI; OQ-45 (Symptom Distress, Relationship Distress, Social Role Conflict) Pre-intervention (T1) Post-intervention (T2)</td>
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<td>Emotional Support group</td>
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<td></td>
<td>Eating Disorder (Anorexia Nervosa, Bulimia Nervosa, &amp; Eating Disorder Not Otherwise)</td>
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</table>
Specified intervention (T2) showed improvements significantly more quickly (first 4 weeks).

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Interventions</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosmarin, Pargament, Pirutinsky &amp; Mahoney (2010; USA)</td>
<td>N=125 Subclinical anxiety</td>
<td>Spiritually integrated treatment (SIT) N=36</td>
<td>Pre-intervention (T1); Post-intervention (T2); 3-month follow-up (T3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Progressive Muscle Relaxation (PMR) N=42</td>
<td>Global Jewish Religiousness Prior to commencement of intervention (T1) TIG; MIG; JCOPE Pre-intervention (T1); Post-intervention (T2); 3-month follow-up (T3)</td>
</tr>
</tbody>
</table>
BAI – Beck Anxiety Inventory (Steer & Beck, 1997); BCOPE – Buddhist Coping; BDI(-II) – Beck Depression Inventory; BSQ – Body Shape Questionnaire (Rosen, Jones, Ramirez, & Waxman, 1996); CES-D – Center for Epidemiological Studies Depression (Radloff, 1977); CIRS – Cumulative Illness Rating Scale (Linn, Linn, & Gurel, 1968); CGI-S – Clinical Global Impression Severity (Busner & Targum, 2007); DAS – Duke Activity Status Index (Hlatky, Boineau, Higginbotham, Lee, Mark, Califf & Pryor, 1989); DSSI – Duke Social Support Index (Koenig, Westlund, George, Hughes, Blazer, & Hybels, 1993); EAT – Eating Attitudes Test; EWB – Existential Well-Being; GDS – Geriatric Depression Scale (Yesavage & Sheikh, 1986); GSI – Global Severity Index; HAM-A – Hamilton Rating Scale for Anxiety (Hamilton, 1959); HRSD – Hamilton Rating Scale for Depression (Hamilton, 1960); IUS – Intolerance of Uncertainty Scale (Buhr & Dugas, 2002); JCOPE – Jewish Coping; LOT-R – Life Orientation Test-Revised; MIG – Mistrust in God (Rosmarin et al, 2009); MINI – Mini International Neuropsychiatric Index; MSEI – Multidimensional Self Esteem Inventory (O’Brien & Epstein, 1998); NRC – Negative Religious Coping (subscale of RCOPE); OQ-45 – Outcome Questionnaire (Lambert & Finch, 1999); PDS – Posttraumatic Stress Diagnosis Scale (McCarthy, 2008); PHQ-15 – Patient Health Questionnaire Somatic Symptom Severity Scale (Kroenke, Spitzer, & Williams, 2002); PRIME-MD – Primary Care Evaluation of Mental Disorders (Spitzer et al, 1994); PSS – Perceived Stress Scale (Cohen, Kamarck, & Mermellstein, 1994); PSWQ – Penn State Worry Questionnaire (Meyer, Miller, Metzger, & Borkovec, 1990); RCOPE – Religious Coping; RWB – Religious Well-Being; SAS(-SR) – Social Adjustment Scale(-Self Report) (Mundt, Marks, Shear, & Greist, 2002); SWBS – Spiritual Well-Being Scale; TIG – Trust in God (Rosmarin et al, 2009)
Overview of included studies

Characteristics of participants

Half of the reviewed studies (N=4) recruited participants that were assessed to have clinical and major depression, with a further two studies recruiting those with Generalised Anxiety Disorder (GAD), or subclinical anxiety, one recruited those with an eating disorder, and one those with self-reported symptoms of trauma. The included studies consistently reported that female participants were in the majority.

In the eight included studies, there was a majority representation for those of a Christian religion; other religious beliefs reported include but are not limited to Judaism (e.g. Rosmarin et al, 2010), Jesus Christ and the Latter Day Saints (LDS), Buddhist and ‘other’ (e.g. Richards et al, 2006). Whilst two studies disclosed the ethnicity of participants, this only denoted the percentage of Caucasian participants (Koenig et al, 2015b; 58.2% CCBT, 47.7% RCBT; Richards et al, 2006; 97.5% total). None of the other included studies made reference to the ethnicity of participants.

Design

For those recruited to the intervention groups, the number of participants ranged from 11 (Koszycki et al, 2010) to 65 (Koenig et al, 2015b), with the mean sample size being 40.6 (SD= 22.5).

All of the studies included control or comparison groups, where individuals were randomly assigned to intervention or control and/or comparison groups. This means that all participants were recruited from the same population. However, differences can be found among the methods of randomisation adopted. Two studies used computer
generated randomisation (Koenig et al, 2015b; Rosmarin et al, 2010) where another used scorings on a measure to pair participants, and then randomised using a table (Bowland et al, 2012). The remainder of the studies (N=5) were either unclear about their methods of randomisation, stating only that this occurred, or employed alternative methods, e.g. block design procedure (Propst et al, 1992). For seven of the included studies, the control or comparison group received an intervention.

Six of the included studies involved individual interventions that were conducted remotely (e.g. Rosmarin et al, 2010; mixture of Skype, telephone contact and online). Two of the included studies used group interventions (Bowland et al, 2012; Richards et al, 2006).

All studies used a measure of religiosity or spirituality at baseline, and five studies then followed this up post-intervention and at follow-up. All measures of mental health were administered at both pre- and post-intervention. Follow-up intervals ranged from 4 weeks (Koenig et al, 2015b) to 24 months (Propst et al, 1992).

**Measure of spirituality or religiosity**

It is not feasible here to describe all the measures that were used in the included studies for religiosity and spirituality, due to their breadth and variation. All measures are included in Table 1. Measures that were used in two or more of the studies will be described in more detail.

Two of the included studies measured participant’s religiosity using the Duke Religion Index (DRI; Koenig et al, 1997). The DRI comprises 5-items that look to an individual’s non-organisational and organisational religiosity, as well as the intrinsic aspects of religiousness (Storch et al, 2004). The questions pertaining to organisational religiosity
(one-item; how frequently an individual attends formal religious services) and non-organisational religiosity (one-item; how often an individual takes time for private religious activities), are measured on a six-point frequency scale anchored at ‘1 (never)’ to ‘6 (several times a week)’. The three-items relating to intrinsic religiousness explore the degree to which religiousness is integrated into an individual’s life. This is measured on a 5-point frequency scale from ‘1 (definitely not true)’ to ‘5 (definitely true)’. The DRI has been found to have excellent internal consistency (Cronbach’s alpha = .91) and good concurrent validity when correlated with the Santa Clara Strength of Religious Faith Questionnaire-Short Form (SCSRFQ-SF; Plante, Vallaey, Sherman, & Wallston, 2002) wherein $r(523) = .86$, $p<.0001$. (Storch et al, 2004).

Three studies chose to measure religiosity using variations of the Religious Coping scale (RCOPE; Pargament et al, 1997) or selected subscales herein (e.g. Interpersonal Religious Discontent; Bowland et al, 2012). The variations included the BriefRCOPE (Pargament, Feuille, & Burdzy, 2011; in Pearce & Koenig, 2016), the JCOPE (Jewish religious coping; Rosmarin, Pargament, Krumei & Flannelly, 2009; in Rosmarin et al, 2010), and the BCOPE (Buddhist coping; Phillips et al, 2012; in Pearce & Koenig, 2016). The RCOPE is a multi-functional tool whose questions are designed to capture and reflect the following five religious functions; control, comfort, meaning, life transformation and intimacy (Pargament et al, 2011). It is assumed that the measures pertaining to intimacy and comfort are likely to reflect the spiritual functioning of religiosity. Investigations into the RCOPE’s psychometric properties have provided evidence for high internal consistency and validity, where the majority of its subscales receive alpha values of $\geq 0.80$, indicating high reliability (Pargament et al, 2011). When measuring religious coping, the full RCOPE provides a sound, theoretically-based and broad tool, allowing it to be adapted for specific religious affiliations, as in the included studies.
Despite there being a range of measures used across the studies to measure religiosity and spirituality, a shared difficulty is their reliance on self-reported data. Whilst self-report is the most appropriate modality of measuring the intended constructs, it is important to consider and remain aware of the openness to bias. For example, participants may have been aware of the purposes of the interventions. This may have impacted their responses, knowingly or unknowingly, and therefore calls into question the validity of the studies that have used this approach.

Quality of included studies

The included studies were evaluated as reasonable in quality, with ratings ranging from 41% to 67%; see Appendix D for a full overview of ratings. Generally, the assessment criteria and methods of allocation were well covered. The included studies provided detailed information regarding participant eligibility and recruitment, as well as suitable methods to allocate participants to groups (both treatment and comparison/controls) and length of exposure to the interventions. Studies also used adequate outcome measures for the rationale and appropriate statistical analyses, allowing tentative interpretive findings. Consistently poor scores were recorded in some criteria of note. Low ratings were given for participant representativeness of the population area (items 1.2-1.3). Evidence for this item was often unreported, or not reported to an adequate extent for rating, for example the omission of key demographic details; ethnicity. Alongside this, the representation of participant demographics was often poor (e.g. the majority of participants were white female Christians). The implications of this extend to the generalisability of the findings (item 5.2), which then also scored poorly. This was resultant of poor representation, and the majority of studies (N=7) being conducted in the United States. In turn, this means
that the findings from these studies are likely not generalisable to other areas. There was also a marked weakness on follow-up times (item 3.5-3.6). Though the studies scored reasonably well on these items, this was with reference to measures pertaining to mental health. Three of the included studies did not follow up measures of religiosity or spirituality beyond baseline, leading to further impacts upon the studies’ generalisability. Furthermore, marked weaknesses and omissions were evident with regards to how the studies were powered (item 4.3). Where two of the included studies were not powered to detect the appropriate treatment effect, a further three studies made no report on this. As a result, any conclusions that are drawn from the literature as a collective should be done so with caution.

Despite these shortcomings in quality assessment, the findings of the included studies remain relevant, though as noted there are implications for interpretations made.

**Effectiveness of interventions**

**Nature of interventions**

Despite their commonalties, the included studies remained largely heterogeneous, with variations primarily in their methods of delivery. Half of the included studies (N=4) focused on religiously integrated interventions, whereas the remaining four focused on spiritually-informed interventions, wherein two utilised groups; all of which are described in more detail below.

It is thought that utilising someone’s existing religiosity and spirituality, is helpful to them when they experience mental health difficulties (McCarthy-Jones et al, 2013). However, just as the efficacy of pharmacology interventions may vary from patient to patient, religiously or spiritually informed interventions may also not be effective for
everyone. All of the interventions across the eight included studies integrated religion or spirituality as a key component, which is why they have been considered in this systematic review.

The helpfulness of spirituality has been well documented. Pollner (1989) reports that the relationship an individual has with a divinity can affect their coping abilities in so far as being a positive resource to draw on in times of need. Further to this, religious coping has been shown as a mediator accounting for the relationship between mental health and spirituality, namely in periods of distress (Cornah, 2006). Pargament et al (1997) have conceptualised this in the form of a measure; the RCOPE. They also report that religiosity and spirituality supports perceived locus of control and attributions. Aukst-Margetić and Margetić (2005) state that holding religious beliefs may allow individuals to reinterpret and reframe occurrences that appear uncontrollable in order to reduce their distress. This assures that an individual may attribute negative events to something beyond themselves (Aukst-Margetić and Margetić, 2005), avoiding disempowerment and self-blame.

There is, however, evidence that religiosity and spirituality can prove to be a hindrance in times of distress. McCarthy-Jones et al (2013) propose that those who are spiritual but not religious, do not have the same social support of a religious community to turn to. Indeed, this poses a risk of isolation leaving their distress unspoken and unchecked. Borras, Mohr, Brandt, Gilliéron, Eytan, and Huguelet (2007) report that spirituality and religiosity can delay help-seeking which may result in missed opportunities for pharmacological or psychotherapeutic interventions that may otherwise have been successful. There is evidence to suggest that a large proportion of those who are spiritual or religious will turn to members of the clergy before presenting and disclosing to services (Moss, Fleck & Strakowski, 2006). Though Borras et al (2007) focus on schizophrenia, it is likely that such evidence is transferable to other mental health
difficulties. As there are contradictions in existing literature however, recognition for the pros and cons to the integration of religion and spirituality within mental health care was maintained.

Due to the research base evidenced above, the present review assumed the authors of the included studies were approaching their research with a view of religion or spirituality being helpful and efficacious.

**RCBT-based interventions**

Four of the included studies employed Religious Cognitive Behaviour Therapy (RCBT). Koenig et al (2015b) and its two subprojects (Koenig et al, 2015a; Pearce & Koenig, 2016) used an RCBT protocol that followed the same principles as conventional CBT (CCBT). RCBT was adapted to use religious beliefs when identifying and replacing participant’s unhelpful behaviours and thoughts by way of reducing their symptoms of low mood. For example, participants were provided with passages from Holy Scripture and encouraged to use it when challenging and changing unhelpful thoughts. RCBT is therefore a religiously informed psychological intervention, used here with individuals experiencing major depression.

The RCBT protocol was informed by Pearce et al’s (2014) manualised Christian RCBT though it was adapted and the interventions supervised by faculty members prescribing to Jewish, Hindu, Buddhist, and Muslim religions (Koenig et al, 2015b). Participants were randomised to a treatment condition that was delivered remotely via telephone, online, or Skype. In Koenig et al (2015b) the overall sample displayed reductions in their BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) scores from baseline to 12-week follow-up. However, no significant difference was found between RCBT and CCBT conditions. There was no control group, only a comparison, therefore it can only be
inferred that RCBT and CCBT are as efficacious as each other, with no comparisons
drawn to the results of those not treated. Their intention to treat (ITT) analysis displayed
an interaction between the RCBT group and overall religiosity; offering that RCBT is
more efficacious in those with high religiosity. Therefore, RCBT may be more effective
than CCBT for those with depression that indicate high religiosity.

The two subprojects of this study (Koenig et al, 2015; Pearce & Koenig, 2016) utilised
the same population sample, though focussed on the effects of RCBT and CCBT on
optimism and spiritual struggles (conflict with a Higher Power, oneself, or others)
respectively. In Koenig et al (2015) no significant differences were found in the effects
of RCBT and CCBT on the LOT-R (Life Orientation Test-Revised; Scheier, Carver, &
Bridges, 1994). Higher baseline religiosity, as measured by the Duke Religion Index
(DRI; Koenig et al, 1997) gave a greater predicted increase in optimism over time. There
are, however, limitations with these findings. As this was a subproject, the study was
designed to compare RCBT and CCBT on depressive symptoms rather than optimism;
the study was not powered to detect a treatment effect in the event that one occurred. To
some extent this echoes the findings within the parent study that a higher level religiosity
in individuals provides better results with RCBT than CCBT. Pearce and Koenig (2016)
displayed similar findings; spiritual struggles did decrease in participants over time,
though no evidence was shown that indicates RCBT to be more effective than CCBT.
However, high religiosity at baseline did not impact on the findings in the RCBT and
CCBT groups, indicating neither was more efficacious than the other. As the same
sample of participants were utilised and the subprojects were not powered to detect the
desired treatment effect, it provides only tentative evidence for the effectiveness of
RCBT over CCBT.
Propst et al (1992) also used religiously adapted cognitive therapy (RCT), with primary focus on behavioural experiments and cognitive restructuring. Religious adaptation meant offering alternatives to unhelpful thoughts with arguments based in religion, and offering Christian rationale for procedures; all of which was done drawing on Propst’s (1988) religious cognitive treatment manual. Again, participants were randomised to either receive treatment (RCT or NRCT; Non-Religious Cognitive Therapy), pastoral counselling (PCT), or to the wait list control (WLC) condition. A block design procedure ensured that both religious and non-religious therapists saw individuals in both conditions (RCT-Religious Therapist, NRCT-RT, RCT-Non-Religious Therapist, NRCT-NRT). Treatment occurred for eighteen 50-minute sessions across both conditions. The authors found a significant reduction in participants’ scores on the BDI (Beck et al, 1961) for those in the RCT condition when compared with WLC; with those in the NRCT and PCT conditions showing reduction in BDI scores that trended towards significance. These findings were consistent across all general and social adjustment scores. They also found that RCT produced decreased scores on the measures at follow-up (3- and 24-month). Follow-up data was gathered from all the participants at 3-months (N=48), with only two participants failing to provide feedback at 24-month follow up (N=46). The increased comparability of interventions utilised here allows the superiority of RCT to be inferred.

All of the above studies benefitted from a controlled, randomised design with all conditions being recruited from the same population. For studies employing a religiously informed CBT-based intervention (N=4), improvements on measures of mental health difficulties were largely found to be superior to the comparison treatment and control groups, wherein the majority were significant. Follow-up data consistently provided evidence for the superior efficacious nature of religiously informed interventions, as opposed to its traditional counterpart. Bearing in mind the paucity of the research within this area, this allows for a tentative interpretation of these interventions being more
effective when used with the appropriate population. As Propst et al’s (1992) study is over two decades old a replication of their research could provide beneficial evidence for adapted interventions. This would identify societal changes in relation to the discourse of religion and spirituality within mental health care. Moreover, it is important to recognise that three of the above studies were conducted with the same sample of participants. This leaves reliance on two studies to evidence the effectiveness of RCBT, allowing for the inclusion criteria of the present review.

**Spiritually informed interventions**

Of the remaining studies (N=4), the interventions drew more broadly on spirituality, wherein there were two individual intervention studies and two studies employing group intervention. Rosmarin et al (2010) utilised a spiritually integrated treatment (SIT) specifically within the Jewish community. The authors worked with Jewish leaders and teachers to effectively identify strategies specific to their faith for coping with stress and worry. There were two broad categories utilised in their intervention programme; cognitive (e.g. reading texts from Jewish literature and other inspiring stories), and behavioural (e.g. prayer and exercises known to increase gratitude) (Rosmarin et al, 2010). In the SIT group, participants were exposed to the cognitive focussed aspects of treatment to begin with and were then encouraged to undertake Jewish spiritual exercises. Treatment period for both the SIT and comparison groups lasted 2 weeks, with the programs being of approximate equal length; 25-30 minutes. Participants were randomised to a condition, SIT, progressive muscle relaxation (PMR), or WLC, and therefore had no say in the treatment being received. The authors reported that more individuals randomised to the SIT group completed treatment, than those in PMR. At post-treatment the SIT group reported lower levels of intolerance of uncertainty, worry,
mistrust in God, and increased levels of positive religious coping; results that remained at 3-month follow-up. This study would have benefitted from further follow-up data to determine the extent of SIT’s effect. An additional analysis was completed to determine whether Orthodox affiliation bore any relation to treatment outcomes, though it was found that there was equal likelihood of treatment effects in Orthodox and non-Orthodox participants. This suggests limited variation across denominations, though there is not enough information to determine whether this is down to the differences between the participants or the differences in interventions.

Koszycki et al (2010) also utilised a spiritually-based intervention (SBI). In this study, participants were randomised to either receive standard CBT or SBI. Those in the SBI condition were provided with twelve 50-minute individual sessions by a spiritual care counsellor who was an ordained minister with a doctorate in pastoral psychology. Here, the SBI focused on an individual’s spiritual growth and well-being, following teachings and exercises from Essential Spirituality (Walsh, 1999). Within this text, the spiritual practices are derivative of Christianity, Buddhism, Hinduism, Islam, Judaism, Taoism, and Confucianism. It aims to cultivate spiritual wisdom and awakening, a calm and concentrated mind and ethical living. Both those with diverse religious and spiritual backgrounds, and those with no affiliation were eligible to participate; including Christians (N=14), Jewish individuals (N=1) and those with no religious affiliation (N=7). The authors found significant post-treatment improvements for both the SBI and CBT conditions, where the scores remained lower than baseline at follow-up (3- and 6-month). The results suggest that while a spiritually informed intervention is beneficial it is no more efficacious than standard psychological treatment. The authors report that the majority of participants completed at-home spiritual exercises (e.g. prayer, meditation); though as with self-report measures, this is open to bias.
Individuals benefitted from receiving spiritually informed treatments, however the findings are not as significant or concrete as those described in the religiously informed interventions. Improvements were seen across all measures used that trended towards significance, therefore tentative conclusions can be drawn as to the effectiveness of spiritually-informed interventions. Methodological weaknesses, including their generalisability, also inhibit more well-founded conclusions.

**Spiritual group interventions**

The remaining studies for review here employed group interventions. Richards et al (2006) worked with females on an eating disorder inpatient unit over a period of 15 months who, during their stay, were offered and then randomised to either a spiritual, cognitive or emotional support group. All groups took place weekly for 60 minutes. For those in the spirituality group, they were asked to read Spiritual Renewal: A Journey of Faith and Healing (Richards, Hardman, & Berrett, 2000). This is a self-help workbook that includes educational readings (traditional of Judeo-Christianity) such as prayer and forgiveness, as well as spiritual readings that do not prescribe to a denomination. Within the weekly group, participants were encouraged to share what they had learnt during the week with regards to their personal spirituality, whilst drawing on the provided texts (Richards et al, 2006). The authors note a consistent pattern of significance on measures for those in the spirituality group, offering that the treatment enhanced the effectiveness of the inpatient programme overall. Namely, those in the spirituality group attained significantly greater reductions on the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979) than those in the cognitive group (the intervention recommended for those with an eating disorder). This suggests that utilising a spiritually informed treatment is beneficial in its rate of reducing eating disorder specific symptoms. Moreover, significant
differences were identified within the spirituality group for their higher ratings of religious and existential well-being, from baseline to post-treatment, than those in the cognitive and emotional support groups.

Similarly, and again with an all-female participant sample, Bowland et al (2012) randomised individuals experiencing trauma symptoms to either the spiritual treatment group, or control, where no intervention was provided. The spiritual intervention was devised collaboratively by practitioners and trauma survivors with a view to addressing possible spiritual struggles in recovery (Fallot & The Spirituality Workgroup, 2001-2004). A manualised skill-building, cognitive restructuring and psychoeducational protocol was devised. Participants received eleven sessions with broad themes as outlined above. The authors report that participants in the treatment condition displayed both clinically and statistically significant reductions in their symptoms of trauma and trauma-related mental health symptoms, when compared with the control. This suggests that participants in the treatment group benefitted from the spiritual adaptations. However, with no comparison treatment to be compared with, this should be interpreted with caution.

Overall, the studies pertaining to spiritually informed group interventions, as opposed to individual interventions, appear to demonstrate superior results; wherein, more significant differences were found between the group interventions and their comparison or control counterparts. However, this suggestion can only be made and interpreted with caution as these integrated interventions have not been widely studied in relation to their use with mental health difficulties. Moreover, methodological weaknesses, including their generalisability, do not allow for more conclusive interpretations. Nevertheless, it could be suggested that it is more beneficial for individuals to access spiritually informed interventions within a group setting as opposed to individually.
In summary, though the literature is sparse, and individual studies fall subject to methodological flaws, when considered as a body of literature the support is positive and durable. Though, as has been noted, these limitations warrant caution in interpretation. As a collective, data is provided on how such adapted interventions compare with more traditional counterparts (N=7) or control groups (N=1). Information is also available for the effectiveness at follow-up, furthering the consideration and speculation for the duration and method of intervention required for meaningful change.

Discussion

This review aimed to examine the effectiveness of spiritually or religiously informed interventions for individuals experiencing mental health difficulties. The quality of the literature base was reviewed, as well as measures of spirituality and religion, and the type of interventions employed.

Overall summary of findings

The included studies used different measures to address an individual’s spirituality and religiosity. Two studies used the Duke Religion Index (Koenig, Parkerson, & Meador, 1997), 3 studies used the RCOPE (Pargament et al, 1998) or a variation of this (e.g. the BCOPE; Pearce & Koenig, 2016), and others used a variety of measures including those that sought to identify an individual’s relationship with spirituality or religion, the extent to which this featured in their lives (Hall & Edwards, 1996), and their trust or mistrust in God (Rosmarin, Pirutinsky, & Pargament, 2011). However, three of the studies only used these measures at baseline, therefore no change in religiosity or spirituality could be
tracked. This inconsistency in the measures used not only has implications for their reliability in interpretation, but it also echoes an earlier sentiment whereby disagreements exist in defining and measuring these constructs. This is understandable given the subjective nature of such beliefs and experiences; it is difficult to devise a scientific measure to capture a generalised view of individual relationships with spirituality and religion.

Further to this, all eight studies used self-report measures pertaining to mental health and spirituality and religion. Self-report measures are inherently flawed and open to biases, as there is reliance on wholly honest answers from the participant. Therefore, caution should be exercised when interpreting the results.

All the included studies utilised an intervention that was religiously or spiritually informed. Four studies employed religious-CBT (Propst et al, 1992; Koenig et al, 2015a; Koenig et al. 2015b; Pearce & Koenig, 2016) with others employing individual or group interventions that were informed by either spiritual texts (e.g. Koszycki et al, 2010) or by consultations with religious clergy (e.g. Rosmarin et al, 2010). This allowed the interventions to adequately account for individuals’ beliefs. Further to this, individuals within the studies experienced a range of mental health difficulties; two studies intervened with those experiencing anxiety (GAD; Koszycki et al, 2010; subclinical anxiety; Rosmarin et al, 2010), four studies with those experiencing depression, namely within a chronic medical illness context (Propst et al, 1992; Koenig et al, 2015a; Koenig et al, 2015b; Pearce & Koenig, 2016), one study working with older trauma survivors (Bowlanet al, 2012), and one working with inpatients for treatment of an eating disorder (Richards et al, 2006). This variety of mental health difficulties allows for a certain level of generalisation within the findings reported here. However, such a range
also makes comparisons of findings difficult, e.g. clinical discrepancies exist around the complexities of treating mental health difficulties requiring inpatient treatment to those within the community.

As noted, due to the heterogeneity of the included studies, a meta-analysis was not deemed appropriate for the current review of effectiveness. Therefore, a qualitative approach was employed using narrative synthesis.

Are religiously or spiritually informed interventions effective for individuals experiencing mental health difficulties?

All of the included studies sought to identify the effectiveness of a religiously or spiritually informed intervention for individuals experiencing mental health difficulties. Four of the included studies used an intervention that was notably religiously informed, and the remaining four studies used notably spiritually informed interventions. Though some similarities are evident between the interventions, the results should be interpreted with caution as a variation of manualised texts and protocols were drawn upon. The quality of all eight studies is varied. Methodological shortcomings tended to revolve around a distinct lack of reporting regarding ethnic diversity, applicability to the UK population, and lack of sufficient follow-up of the spirituality or religiosity measures. Nevertheless, when acknowledging these studies as a collective it is possible to draw some conclusions about the effectiveness of such adapted interventions.

Four studies examined the effectiveness of a religiously adapted CBT intervention on individuals with depression. All the studies utilised the Christian CBT protocol set out by Pearce (1988; 2014) though the lengths ranged from ten to eighteen 50 minute sessions.
Whereas Propst et al (1992) only employed a Christian version of religious CBT, the remainder of the studies adapted this protocol for other religions; Jewish, Muslim, Hindu, and Buddhist. Differences can also be found in who delivered the therapy. Propst et al (1992) used therapists in a religiously oriented clinical psychology programme. The other studies of RCBT used therapists who were supervised by the faculty members involved in the intervention adaptation. It is likely, therefore, that the therapists directly involved in religiously oriented training were biased towards the intervention being more effective than its conventional counterpart. The quality of the four studies was also varied. The shortcomings in methodology typically involved lack of follow-up data on spirituality or religiosity measures, and limitations in the comparability to settings outside their context. When viewing the studies as a whole however, it is possible to draw conclusions about the effectiveness of RCBT on individuals with depression. In general, this intervention appeared to be effective, where one study found significant decreases in symptoms compared to the WLC group. Improvements were seen across all studies, and these were sustained at follow-up; ranging from 3- to 24-months. However, the majority of the studies (N=3) found only that RCBT was effective yet not more so than conventional CBT. It is possible, as the authors remark in their own discussion, that as CBT for depression has found to be effective on the whole that RCBT could not make it more effective. It was also noted that it is possible that those recording higher religiosity at baseline measurement would benefit more from a religiously-informed approach.

Two studies examined the effectiveness of interventions informed by spirituality. One study adapted its intervention using a spiritual text (Essential Spirituality; Walsh, 1999), and the other was informed by Jewish clergy so that specific spiritual coping styles for the population were identified. Variations are noted in the delivery of the interventions. Koszycki et al’s (2010) programme consisted of twelve 50-minutes individual sessions, conducted by a spiritual care counsellor. Rosmarin et al (2010) on the other hand utilised
a 2-week treatment period, where participants navigated various stages of the treatment programme. It was unclear who delivered this. This may have led to researcher bias within the former study, as has been noted with reference to the RCBT studies. The studies scored identically on the quality checklist, though shortcomings were noted in their generalisability to other populations. Effectiveness in the spiritually-informed treatments was mixed; where one study found a significant difference in the measures used, the other study found only a trend towards significance, when compared with controls. These findings are not as conclusive as those found for RCBT as an effective intervention. It is reasonable to postulate therefore that this may be due to the concreteness associated with religion, whereas spirituality is more amorphous. This may not transfer effectively to manualised and programmed treatments for mental health difficulties.

Finally, two studies used spiritually informed interventions in group settings. One study adapted its intervention using a spiritual text (Spiritual Renewal: A Journey of Faith and Healing; Richards et al, 2000) that was implemented weekly during a 60-minute group. The other employed a manualised protocol that involves psychoeducation, cognitive restructuring and a skill-building approach (Fallot & The Spirituality Workgroup, 2001-2004). Here eleven 90 minute sessions formed the intervention. A stark difference noted here is that the individuals receiving the spiritual text based intervention were inpatients on an eating disorder ward, whereas those receiving the manualised approach were community dwelling. This could affect the scores on the self-report measures, as one group of participants will have self-selected into the study, whereas the others were being offered it as part of their treatment programme. Both studies, however, showed significant reductions in mental health symptoms at completion and follow-up. This allows for a conclusion of the positive impact of spiritually informed group interventions to extend beyond community-based approaches. The quality of the included studies,
however, was mixed. Particular shortcomings are found in the generalisability of the findings, not only due to its context but also as all the participants across the two studies were female. Consequently, this leaves room for question as to whether the same treatment effects would be displayed in a male population.

In summary, promising results have been shown for the effectiveness of spiritually or religiously adapted therapies. Though some interventions provided more significant results than others, this could be due in part to the variations in outcome measures chosen. A vast number of outcome measures were identified across the eight included studies here, therefore reducing comparability. Religiously informed interventions also provided more consistently significant results, which could be as a result of being more measureable. As was alluded to earlier, the concreteness of religion, when compared with spirituality, may lend itself not only to clearer manualised intervention protocols, but also to measureable constructs. The alternative to this, however, is that though spirituality is more amorphous, general themes can be extracted. The differences between religious denominations can be stark, therefore where Propst et al (1992) used only Christian RCBT and found significant results, Koenig et al (2015) adapted the interventions for different religions, drawing from this manualised text. No significant differences in effects were noted here. It is possible that this is because other religions are not as suitable to CBT as Christianity, or that the variance in therapists account for these differences.

Given the potential benefits of adapted interventions, attention should be paid to utilising them where appropriate, as well as investigating and developing them further. The interventions and studies reported here are not without their flaws and variations, therefore implementation is recommended only under supervision or with appropriate training.
Limitations of the review

This review has systematically appraised the available literature pertaining to the effectiveness of spiritually or religiously informed interventions for individuals with mental health difficulties. As this is an emerging area of quantitative study the scope of this review is limited, in part due to the quality of the studies available and the measurability of spirituality and religion. Shortcomings with regards to methodological quality included solely statistical analysis of the data, lack of relevant follow-up data, and variations and lack of information in participant demographics, namely their ethnicity. Research has demonstrated that members of ethnic minority groups can be more likely to practise their religious beliefs than Caucasians (e.g. Esser-Stuart & Lyons, 2002) as well as being more likely to regard their spirituality as a fundamental facet of their health care (Devlin, Roberts, Okaya, & Xiong, 2006). They are also more likely to make use of religious coping during difficult times (Dunn & Horgas, 2004). For the included studies to increase their generalisability this variable would need to be addressed. The present review does not allow for this therefore it is difficult to ascertain whether this cultural group would show similar results to the Westernised participants of the included studies. Of these all but one of the studies was conducted in the USA. Further to this, generalisability of the findings is also impaired where two of the included studies are sub-projects of a parent study (Koenig et al, 2015b, acting as a parent study to; Koenig et al, 2015a and Pearce & Koenig, 2016). Though they look to investigate, in more detail, certain characteristics that may be affected by the adapted intervention (i.e. optimism and spiritual struggles), this means that around 26% of the included studies display findings from the same pool of participants.
The scope of the present review is not only impacted due to the body of literature, but also in part due to limitations put on the search criteria. Research studies exist that have assessed the effectiveness of religiously or spiritually-informed psychological interventions, yet some were excluded if they did not use a measure of mental health difficulty. Such research has assessed interventions with regards to their impact on well-being and life satisfaction, focusing on more positive psychological constructs than the diagnostic approach of the included studies in this review (e.g. Wu & Koo, 2015). This does, however, allow for future research to undertake a review of such literature, perhaps drawing comparisons from the present review.

A further limitation lies in biases. Where it is assumed that the authors of the included studies are approaching their research from a stance of spiritually or religiously informed interventions being helpful, this indicates a preference; therefore, a researcher bias. This was highlighted where some studies used therapists either of specific religious denomination, or enrolled within a religiously-oriented clinical psychology programme. Selection bias was also noted throughout the majority of the studies (N=7). Participants were recruited through advertisements; one study advertised in Christian media (Propst et al, 1992) and others in hospitals or other clinical settings. This therefore limits the generalisability of the findings. It is important to consider the individuals that will have been missed from this research due to not registering interest, as well as considering how appropriate these interventions would be for those that do not ascribe to a religion or spirituality.

Conclusions, implications and directions for future research

The present review indicates that interventions that are adapted to be spiritually or religiously informed have the potential to be more beneficial to those with such
affiliations rather than conventional interventions. This review aimed to assess the effectiveness of such adapted interventions for those experiencing mental health difficulties. With the exception of Koenig et al’s (2015b) randomised clinical trial that was used as a parent study for two further studies used in this review, none of the interventions followed the same explicit programme. However, in general the results found improvements and therefore attained a positive impact on the reduction of symptoms in participants. One study (Pearce & Koenig, 2016) found that the adapted intervention was equally effective to the control, yet none of the included studies concluded that the spiritually or religiously informed interventions were less effective than the control or comparison group. Shortcomings in the included study’s methodology, however, require that caution is taken when endorsing and implementing such adapted interventions more widely. This is with particular regard to the limited information offered on how the studies were powered to detect a treatment effect, where two studies were not accurately powered. This review, however, does provide initial support for the use of spiritually and religiously informed interventions as a means of helping those experiencing mental health difficulties, particularly those that regard their religion or spirituality highly. This conclusion is in keeping with the findings of meta-analytic (e.g. Smith et al, 2007) and qualitative (e.g. Oman & Thoresen, 2001) reviews of the same topic. As previously noted, the implementation of such adapted interventions would perhaps be most beneficial for those with a pre-existing high religiosity as this was a recurring finding among the included studies in the current review.

Further research is indicated in the need to clarify a unified definition and measurement for spirituality and religion in individuals. Though it is understood that this poses a difficult task, future research could focus on seeking and drawing out commonalities amongst reports of spirituality and religiousness among individuals. This has already begun with the development of the RCOPE (Pargament et al, 1998) and the variations
available of this (e.g. J-COPE, BCOPE) however, there remains room for improvement here. In the meantime, future studies would benefit from making use of the available reliable and valid measures of spirituality and religion so that the data can be more strongly grounded within psychological and sociocultural literature.

A further recommendation lies within service provision. Where it has been noted that a foremost complaint of individuals is that, within services, their spirituality or religion is often ignored or pathologised (Randal & Argyle, 2005), the findings of this review support the recommendation to ask about an individual’s belief system. Though this goes beyond merely talking about an individual’s beliefs, this will open the conversation which could then lead to using an adapted intervention and greater reduction in psychiatric symptoms. This is supported by the findings of this review where adapted interventions for those holding their spiritual beliefs in high regard were more effective than conventional approaches.
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Part Two: Empirical study

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

Journal of Cross-Cultural Psychology

Please see Appendix E for the submission guidelines
“Maybe it’s kind of normal to hear voices”:
The role of spirituality in making sense of hearing voices

Sophie Lewis\textsuperscript{a}, Dr Chris Sanderson\textsuperscript{a}, Dr Anjula Gupta\textsuperscript{a}, & Dr Claire Klein\textsuperscript{b}

\textsuperscript{a}School of Health and Social Work, University of Hull, Aire Building, Cottingham Road, Hull, United Kingdom, HU6 7RX

\textsuperscript{b}Humber NHS Foundation Trust, United Kingdom

\textsuperscript{*}Corresponding Author. E-mail address: S.H.Lewis@2011.hull.ac.uk

Telephone number: +44 (0) 1482 464106

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Abstract

First-person accounts of voice hearing are scarce within qualitative literature, particularly concerning cultural differences. Currently medical or psychological discourses are dominant within research, with little recognition of the exploration of spiritual sense-making and discourses around spirituality. Five participants were recruited from mental health services. Semi-structured interviews were conducted to explore participants’ experience of hearing voices, including influences to their understanding, the role of spirituality, and whether this was helpful or a hindrance. Qualitative data was then analysed using an IPA protocol. Five superordinate themes were identified: inevitability of experience, relationships with others, values about self and identity, processes of change, and sense making. The research findings suggest a relationship between religion and spirituality, and the experience of hearing voices. These experiences relate to the need for belongingness, and self-identity. Implications are considered around creating a shared formulation with individuals, and working at an individual and societal level to support the particular stressors from voice hearing. Future research suggestions are discussed based on shaping the role of services and clinicians’ understanding.
Introduction

‘Voice hearing’ refers to individuals who can hear voices that no-one else can hear, though not necessarily constituting a symptom of mental illness (James, 2001). When presented within a mental health framework however, hearing voices is often perceived as a symptom of another disorder, typically psychosis (APA, 2013). There is a recent shift in thinking in the mental health field, however, with further understanding and appropriate ways of responding to those experiencing psychosis, particularly voice hearing, being sought (Boyd & Gumley, 2007; Clarke, 2013). There is therefore a shift to a more person-centred, collaborative and individualised approach.

The phenomenon of voice hearing has typically been defined under one of three main discourses; spiritual, psychological and medical (McCarthy-Jones, Woegeli, & Watkins, 2013). It can be argued that the predominant discourse under which voice hearing is understood is a medical discourse, evident in the literature both within the UK and internationally. Particular interest is taken with the genetics involved (e.g. Corvin & Harold, 2015) and the efficacy of different pharmacological approaches to treatment (e.g. Abulseoud, Fayek, Kingsbury, & Simpson, 2002). A recent publication by the British Psychological Society (BPS; 2014) has begun to explore and question why people hear voices, offering understandings beyond the medicalised view of ‘psychosis’. Within the psychological discourse voice hearing is beginning to be understood as a product of variations in human experience. Approaches have emerged corresponding with this view such as the Hearing Voices Movement (Romme & Escher, 1987) and voice dialogue (e.g. Stone & Stone, 2011). In voice dialogue individuals are encouraged to respond to and engage with their voices, shifting the focus away from symptom eradication. It could therefore be considered a developing alternative discourse. The primary focus of this paper, however, lies within the spiritual discourse and the journey it has made with individuals who hear voices.
**Spirituality and hearing voices**

In defining ‘spirituality’ there is much debate focussed on the complexities and diversity involved (Moreira-Almeida & Koenig, 2006), though a recurring theme is its relation to the meaning of life (McCarthy-Jones et al, 2013). Formally, the following definition will be followed throughout this paper:

“an inner experience of connection to something greater than oneself, a personal state of the sacred and meaningful” (Lukoff, 2007, p. 635)

It is acknowledged, however, that this definition and meaning are an individualised concept, and so should be understood as such. Furthermore, it should be acknowledged that research is conflicted on the relationship between the constructs of religion and spirituality. Religion can be understood as the denomination an individual prescribes to, where their commitment to the beliefs and practice are inclusive (Hodge & McGrew, 2006). So, where some literature has been known to identify spirituality as encompassing religion (Walker, 2006), differentiated primarily in the lack of organisational practice in spirituality that is commonly associated with religion; others identify only a relationship existing where neither encompasses the other (e.g. Miller & Thoresen, 2003). The stance to be taken throughout this paper is spirituality as the umbrella concept, in keeping with Walker (2006). This ensures that individuals within the study may identify with either spirituality or religion, where disentangling the constructs could prove as a barrier where individuals may identify as religious and not spiritual.

The spiritual discourse around hearing voices in Western cultures is an emerging concept. Clarke (2013) appeals for a movement towards acceptance and appreciation for the
impact spirituality may pose on mental health. Research by McCarthy-Jones et al (2013) complements this: examples of helpfulness of a spiritual understanding of voice hearing were found in enabling coping strategies and social support; however, they found that this sense making may also reduce an individual’s control or aid in the development of dysfunctional beliefs (McCarthy-Jones et al, 2013). International research has also found that individuals experiencing voices may seek out spiritual or religious sources in the first instance, with mental health services being their secondary option for help (Moss, Fleck & Strakowski, 2006; Pargament & Lomax, 2013).

The British Psychological Society (BPS; 2014) acknowledges that different values can be placed on hearing voices, where it is viewed by some individuals, cultures and subcultures as a spiritual gift. Supporting this position are Jones, Guy, and Ormrod’s (2003) findings that some individuals conceptualise and understand hearing voices as a positive spiritual experience, corresponding further with a notion put forward by Pargament and Lomax (2013). Here they posed that a wealth of theory and research indicate that many individuals view religion as a source of strength and resilience. This evidence therefore conveys the possibility that hearing voices can be both a positive and negative experience for some individuals, dependent on their socio-cultural context and belief systems, as well as being an important part of their self and identity.

*Sense-making*

The sense-making process can involve searching for meaning, defining, and rationalisation, where all of these methods are influenced by an individual’s interactions, past experiences, values, beliefs and social construction (Weick, Sutcliffe, & Obstfeld, 2005). This process is important to any individual’s functioning as it seeks to restore the usual order of an individual’s life where there has been a disruption (Weick et al, 2005).
Sense-making is a well-researched construct within voice hearing literature. Pierre Janet is cited describing the sense-making process as a key stage of recovery when an individual has experienced a trauma or significant stress, as may be the case in voice hearing (Van der Hart, Brown, & Van der Kolk, 1989). Janet states that once this stage has been successfully navigated, an individual can regard their experience as meaningful (Van der Hart et al, 1989). The BPS (2014) further identify that the cultural background of individuals should be acknowledged as part of this process. The position statement that is offered by the Division of Clinical Psychology (2013) further argues for understandings of human experience that account for the context within which they occur.

Despite growing interest in those who hear voices there is a paucity of literature addressing first-person accounts of these experiences, particularly how individuals themselves make sense of this. To the author’s knowledge only five qualitative studies have explored this concept (Fenekou and Georgaca, 2010; Holt and Tickle, 2015; Jones, Guy, & Ormrod, 2003; Kalhovde, Elstad, & Talseth, 2014; Minchin, 2017). These studies sought to explore how those with mental health diagnoses manage distressing voices (Kalhovde et al, 2014), how the experience is constructed (Holt and Tickle, 2015; Jones et al, 2003), and the meaning of hearing voices for those experiencing it (Fenekou and Georgaca, 2010; Minchin, 2017). These studies acknowledged the importance of the sense-making process for these experiences and the value of first person accounts.

The rationale for the present study, therefore, reflects the recent shift in research literature to an alternative to the medical discourse, where voice hearing is typically viewed as a symptom of psychosis, towards the exploration of hearing voices as a phenomenon, whereby it is viewed as a rich, meaningful part of human experience. This research does not reject the medical model, however, it is working towards a multi-modal construct of understanding voice hearing. The emerging qualitative research is therefore built on to
allow exploration from a first-person perspective, though is novel in its specific interest in how an aspect of an individual’s context, in this case spirituality, can impact the sense-making of experiences. Where previous research has sought to gain such an understanding overall, the present research hopes to highlight the importance of a person’s context, and therefore a person-centred approach to understanding voice hearing. Further research into a spiritual understanding of voice hearing will therefore help the development of this narrative, in turn supporting the knowledge base of practitioners and voice hearers.

Method

Design

This was a qualitative, single incidence, semi-structured interview based study. Participants that hear voices explored how they made sense of this experience and the role spirituality had in their sense making. Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) informed both the interview questions and the analysis of the interviewees’ response. IPA was chosen as an analytic tool as it is explicitly intended for use in the exploration of experiences and views of the investigated subject.

Research question

a) Does spirituality play a role where an individual is making sense of voice hearing?

b) Where it plays a role, has this helped or hindered the individual’s experience of voice hearing?
Participants

The five participants were aged between 20 and 52 (mean 30.6). Three males and two females participated, and all were white British (see Table 1 for participant demographics). To ensure an appropriately homogenous study population, purposive sampling was employed for in-depth analysis. Recruitment for all participants took place from mental health services within the north of England, where the following criteria was met:

1) self-reported voice hearing as the main reason for being involved in mental health services;

2) currently at a clinician-established level of stability, with no suicide attempts or involvement with Crisis services in the last 6 months;

3) had ability and capacity to provide informed consent (see Appendices F & G for participant information and consent procedures);

4) their experiences of hearing voices were not solely attributable to substance use;

5) fluent English speaking;

6) aged over 18 years at the time of the interview.

Six individuals registered an interest in participating in the study, however one individual was not fluent English speaking, therefore in accordance with the study’s ethical approval (see Appendix I) this individual was not included.
Procedure

The initial contact with potential participants was made by care co-ordinators and link psychologists; they were provided with the study information sheet including the aims and procedures (see Appendix F). At initial contact, the professional involved would ensure they were satisfied that the potential participant was at a clinician-established level of stability, e.g. they would not find the process of the interview distressing. Individuals who registered an interest in participating were then invited to a research interview. They were contacted directly by the lead researcher or through the care co-ordinator.

Interviews were conducted by the lead researcher. Prior to commencement, participants were given the opportunity to ask any further questions and were requested to give their consent and complete a demographics form before interviewing proceeded (see Appendices G & H). Guidance for interviews was taken from a semi-structured schedule (see Appendix J). The interview schedule was informed by recent research into first person experiences of voice hearing (Holt & Tickle, 2015) and investigations into the impact of spirituality on voice hearing (McCarthy-Jones et al, 2013). This satisfied the aim of allowing participants to explore both the potential helpfulness and hindrance that spirituality and religion might pose on their experiences.

The interview schedule covered participants’ initial experience of hearing voices, exploring their understanding, its impact and any influences on this. Their understanding of spirituality; its role in their life, experiences, and contact with mental health services, and whether this was helpful or obstructive was also discussed. Interviews took place during a 4 month period, all were audiotaped and lasted between 22 and 64 minutes (mean = 37 minutes). All audiotaped interviews were stored on an encrypted memory stick and deleted once transcribed. Upon completion of the interview, participants were offered a debriefing sheet detailing further sources of support (see Appendix K).
Participants were assigned a pseudonym to retain anonymity. IPA protocols informed the interview transcription and data analysis (Smith et al, 2009). Close examination of individual transcripts involved making comments of a descriptive, linguistic, and conceptual nature, from which emergent themes were drawn (see Appendix L). Commonalities and differences amongst emergent themes were noted on collation and comparison of the transcripts. Organisation of emergent themes allowed for super- and sub-ordinate themes to be determined, and re-examination of the original transcripts allowed for quotation data related to these themes to be drawn (see Appendix M). Ongoing interaction with the dataset enabled the exploration of the structure and relationships of these themes, allowing for thematic organisation that best represented the information gathered. Transcripts were also shared with supervisors experienced in research to ensure the robustness of the analysis. They conducted analyses on the data that was then compared with the lead researcher’s to increase reliability of the findings.

Table 1. Participant demographics.

<table>
<thead>
<tr>
<th>Participant pseudonym</th>
<th>Gender</th>
<th>Age</th>
<th>Religion</th>
<th>Time since onset of hearing voices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice</td>
<td>F</td>
<td>24</td>
<td>None</td>
<td>11 years</td>
</tr>
<tr>
<td>Jeremy</td>
<td>M</td>
<td>22</td>
<td>Christian</td>
<td>3 years</td>
</tr>
<tr>
<td>Louise</td>
<td>F</td>
<td>20</td>
<td>Buddhist</td>
<td>10 years</td>
</tr>
<tr>
<td>David</td>
<td>M</td>
<td>35</td>
<td>Christian</td>
<td>3 years</td>
</tr>
<tr>
<td>Scott</td>
<td>M</td>
<td>52</td>
<td>Christian</td>
<td>47 years</td>
</tr>
</tbody>
</table>
Researcher’s position

As this study was grounded in an interpretative protocol for its implementation and analysis, the lead researcher’s socio-cultural position and own conceptions will undoubtedly have shaped its process. As a researcher, there is an inherent flexibility to probe any interesting areas that may emerge, and this is required to fairly make sense of an individual’s personal world. It is acknowledged, however, that the lead researcher’s relationship with spirituality and religion allows her to be open to it being helpful and unhelpful in times of need. This is founded in her upbringing, being raised as a Catholic, though experiences in later life allow the recognition of the conflicts that can arise when encountering an experience that goes against such beliefs. Without these values and personal experiences, the construction of the findings set out here may have looked different, and could be interpreted differently by a separate researcher (see Appendix N for the epistemological stance of the researcher).
Findings

The following themes were generated by the researcher, from participant’s accounts in response to the research questions. A summary of the super- and subordinate themes can be found in Table 2. Each participant spoke about the role that spirituality or religion held in their experiences, and the impacts this had for their understanding. The majority of the following themes are therefore intrinsically linked with these constructs, despite no explicit mention of spirituality or religion.

Table 2. Summary of the super- and subordinate themes generated from participant’s accounts.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subthemes</th>
<th>No. participants contributing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inevitability of experience</td>
<td>Expectancy</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Vulnerability vs resilience</td>
<td>3</td>
</tr>
<tr>
<td>Relationships with others</td>
<td>Isolation vs belonging</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Disclosure &amp; seeking help</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Understanding of others (or lack of)</td>
<td>5</td>
</tr>
<tr>
<td>Values about self and identity</td>
<td>Conflicts with beliefs</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Shifts in self-identity</td>
<td>3</td>
</tr>
<tr>
<td>Processes of change</td>
<td>Normality vs reality</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Journey with voices</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Connectedness vs disconnectedness</td>
<td>4</td>
</tr>
<tr>
<td>Making sense</td>
<td>Difficult to express</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>External to self</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Influence of others</td>
<td>4</td>
</tr>
</tbody>
</table>
Theme 1: Inevitability of experience

It felt important for participants to contextualise their experience, to offer the researcher an understanding of the reasons they had arrived at this stage in their lives.

Subtheme 1: Expectancy

Participants described how they may have expected to hear voices, or how when they did it had not come as a surprise to them; “well, who wouldn’t be hearing stuff after listening to that all the time?” (Louise). Participants reflected that hearing voices had not been a confusing or remarkable experience for them due to this expectancy. It felt from the interviews, however, that it was confusing at the time yet reflection clouded their initial responses. David said hearing voices was common within his religion, therefore he was expecting it for different reasons:

“So [pause] so yeah, in my denomination, like speaking to voices was commonplace”

Speaking and conversing with God was encouraged for David and this appeared to allow him a different experience to others. Though some participants reached this same level of expectancy, it was brought about differently. For example, some participants, such as Louise and Alice, expected to hear voices due to other family members sharing this experience. It appeared as normal to them. Whereas others, like David, expected only to hear the voice of God, as was encouraged within his religion. Therefore, hearing other voices, of Satan for example, came as a surprise to him and was a more unnerving and confusing experience.

Subtheme 2: Vulnerability vs resilience

It was often felt among participants that their life experiences had either made them vulnerable to mental health difficulties, or built their resilience. Louise felt that she had
been made vulnerable to hearing voices partly due to her mother’s openness about her mental health:

“I think, she she’s always been, I think, um [pause] look back on it now, maybe too open about certain things, about her mental health, and when I say too open I mean too open for um my younger age”

Interestingly, of the participants who spoke about their vulnerabilities, particularly where it had been a parent with mental health difficulties, they often appeared conflicted as to whether they should rephrase how they spoke about them. This is seen in the [pause] above, and where Alice is describing her upbringing:

“I was mostly raised by my grandmother, but my mum would [pause] I was like introduced to her voices from an early age”

Whereas Louise and Alice are able to reflect that their mother’s openness may have affected their own health, based on their chronological age at the time, Scott felt that he could draw resilience from his more difficult experiences:

“I don’t remember having voices back then, um even though I was under great stress ... [pause] I just made a joke about that because it’s what she was actually doing to me because she was causing me severe problems”

From both positions, responses to sometimes difficult experiences were key to how their voices were shaped and understood. Some, like Alice and Louise, referred to their experiences of family mental health difficulties from a young age increasing their susceptibility to such experiences themselves. However, Scott described how he experienced others who were “causing me problems” yet this felt manageable because he had people to support and protect him. It is possible that Alice and Louise’s experiences did not foster the same resilience because they had no depiction of ‘recovering’ from
mental health difficulties to draw on, e.g. “ever since then she’s still been recovering” (Louise). Scott’s experience was of being “pretty well protected” by his parents, creating a possible hopeful future.

**Theme 2: Relationships with others**

**Subtheme 1: Isolation vs belonging**

The matter of feeling or creating isolation yet seeking and sometimes finding belonging was a repeated theme throughout all participant’s accounts regarding their relation to others. Some participants described becoming “closed in a bit into me shell” (Scott), whereas others described becoming “utterly dependent” (Alice) on their voices, which left her feeling unable to interact with her peers whilst at school. Similarly, as a result of speaking with God and Satan, David felt he needed to isolate himself from the Church community and appeared to be attempting to convince himself that he won’t be persuaded otherwise:

“I still pray, but I’m not going to church. I’m not going to church”

Jeremy felt an increased sense of belonging within his Church community as a result of hearing God’s voice. He spoke about having never met another Christian that had not spoken with God, and heard God speak back. He initially described feeling isolated, and immersed himself in Bible study, though he now offers a different relationship:

“I think when I first became a Christian, I isolated myself. I read the Bible all the time. I was practising my faith and I didn’t have that level of trust within human beings which I now have. It’s honestly… I’ve never been as welcome as I have within a church”
It could be interpreted that this was Jeremy’s penance for his earlier described “immorality”, where he felt he needed to prove himself before truly belonging in the Christian community.

**Subtheme 2: Disclosure and seeking help**

To some participants, disclosing their experience and seeking out help was an important part of the process. Alice described how she delayed talking about her experience because it was “all I’d ever known”, and others held back on sharing their experience for fear that they were “going crazy” (Scott). David spent some time reflecting on how he hadn’t felt as though he needed additional help as he had already sought the help of God:

“and He was giving me really good advice. He’s telling me to, I don’t, really good advice in day to day, you know”

Some participants felt grateful for disclosing their experiences to services. Scott described that this helped him to make sense of his voices “because to me, I was going mad”.

There was a shared concept that disclosure and seeking support was ultimately helpful to the process of understanding their experiences. Though often there was an initial struggle and internal debate, participants did not express any regret in their decisions.

**Subtheme 3: Understanding of others (or lack of)**

All of the participants described the need to be understood, as well as where they had experienced this and where they felt they weren’t understood. Throughout the interviews some participants placed importance on the understanding of the researcher; David asked “did you used to be a Christian yourself?” and Louise sought clarity for the researcher’s understanding of the local area in order to contextualise her experience more effectively:
“Are you from [location]?” “Do you know like the reputation of some of the schools and some of the areas?”

Other participants, such as Alice, spoke about how she felt she “couldn’t talk to [her] friends” because they had not encountered the same experiences as her. Whereas Jeremy felt that once he had explained his faith and his relationship with his voices, this had helped others to understand:

“I told her [care-co] everything Jesus has done in my life from day one. She’s never asked me not to talk about my faith”

It is possible that participants sought to be understood because of others frequently not appreciating their experiences, as well as the stigma that is attached to some mental health difficulties.

**Theme 3: Values about self and identity**

**Subtheme 1: Conflicts with beliefs**

The majority of participants spoke about how their experience of hearing voices, and their values of good and bad or evil had conflicted with their spiritual or religious beliefs. Jeremy described how he “always knew there was something wrong with the world”, whereas others talked about how certain treatments should not work because “that would be like medicating God away” (Scott). In a different way, David spoke about literal conflicts with his voices and values:

“God wants you to, he’s too strict and stuff like that. Yeah. Um [pause] so yeah, I went through a few weeks of talking with Satan”
He spoke about feeling scared of God as what he was saying to him did not match up with what is written in the Bible. As a result, he described talking with Satan who, in turn, built a greater wedge between David and his faith, for example Satan was:

“Um, saying that a good Christian wouldn’t think these things and stuff like that”

All of the participants who spoke about such conflicts did ultimately describe finding resolution and peace. David found this by continuing to practice his faith in prayer; Jeremy articulated how this process had changed his outlook:

“I’ve got redemption. I’ve got peace. I’ve got joy. And I’ve got love. And that’s what God is at the end of the day God is love”

This process of questioning their religious and spiritual understanding appeared as a confusing and fearful time for participants. They began to question the origin of their voices as well as their faith, creating a struggle with their sense of self and the lens through which they viewed the world. Whereas some participants pondered different narratives for understanding the self, this sense of conflict might have determined that there was no good fit, and may supersede understanding.

*Subtheme 2: Shifts in self-identity*

Some participants discussed how their actions and experiences had created a conflict with their view of self-identity. Jeremy described that after becoming unwell initially he returned to University and behaved in ways he did not condone:

“I went back to uni and I remember smoking legal highs. I don’t know why I did it, and I’m obviously ashamed of doing it”

Here, Jeremy speaks of being “ashamed” therefore acknowledging this behaviour as not typical for him, made more powerful stating that he is “obviously ashamed”. He also
acknowledges being unaware of why he did this, addressing the confusion that participants often refer to in relation to their voices and experiences.

Similarly, David described that he was not a “good Christian” and referred to this notion throughout his interview:

“It [stammers] it sort of, sort of [pause] it’s like [pause] before like, before the psychosis like God was everything in my life, at the time. But now um it’s sort of becoming less important which is, which is not a good thing I guess from a Christian perspective”

David’s comment here demonstrates a process of self-reflection and shame that is shared by other participants, considering how his self-identity of being a Christian was challenged following the emergence of voices. David’s difficulty talking about this: “[stammers] it sort of, sort of [pause] it’s like [pause]” illustrates further the impact that his experience has had on his sense of self, and the importance in having a robust self-identity.

Theme 4: Processes of Change

Subtheme 1: Normality vs reality

There was a recurring theme among some accounts of wanting to be normal, but also accepting that what is normal and what is real for participants often do not line up. Alice reflected on the way families are meant to come together following a bereavement and the response of her family:

“None of them wanted to have anything to do with me. None of them wanted me to move in with them, you know, it’s like you read about if someone’s mum died the grandparents automatically step in, but my grandmother didn’t want to do that”
At the time, this was a confusing and isolating period, however Alice is able to reflect candidly on the experience. Similarly, Scott described a process of realisation from childhood to adulthood, where he stated: “I assumed it was normal” because when he told his parents he heard a voice they responded “’it’s just an imaginary friend, there’s nobody there’” Upon the voice reappearing in adulthood, David reflects on a shift from his perceptions of normality to what is real to him:

“This wasn’t until I started seeing these guys [points to care-co] and talking about it, about, the more I talked about it, the more I joined up the dots and realised ‘hang on a minute, I recognise this voice’ and it was the voice behind what was me parents said was just an imaginary friend and wasn’t real”

This shift in appraisal of his voices was a similar theme found with other participants, where what was initially appraised as being normal and expected, was then rejected as not fitting in with societal norms. This acceptance and acknowledgement of experiences not being objectively ‘normal’ could still empower participants and allow them to push the boundaries of normality. Alice reflected this in her response to others and society:

“Ok, these voices may not be normal to you, but I’ll try make them normal to me and that’s all that counts”

Subtheme 2: Journey with voices

All participants described a journey with their voices, whether this was literally in how they were experienced or in how they were able to form relationships and understanding of their voices. Louise spoke about her voices as a commentary, and the change she experienced with this:
“Yeah, like that kind of commentary in your head kind of thing. But then obviously as you grow up, I dunno, things start to get more stressful or something it’s not so much like a light-hearted Peep Show like commentary anymore”

This illustrates that as Louise’s encounters in life had altered and become more stressful, her voices mirrored this. This is likely to lead to an appraisal that when life is calmer her commentary will reflect this, leading to greater understanding of her voices and the way they fit in with her life. Alice reflects a similar process, whereby she describes: “they became my friends, whether I liked it or not they did become my friends because they were all I had”. When asked whether they were still her friends at the time of interview, Alice reflected on her relationship and appraisal of her voices:

“when they’re under control, yes. But I guess that’s of how friendship works because sometimes your friends do get you in trouble and things like that. I mean obviously now they’re under control, yes”

Participants commented on understanding their voices in a certain way, and this appeared irrespective of the length of time they had lived with voices or their understanding of them. Jeremy described how “cold [his] heart used to be before the Holy Spirit entered [him]” acknowledging how his journey with his voices had been influenced by his journey with his faith. He is able to contrast his life not only before and after hearing voices, but also before and after his relationship with God, which strengthened following the emergence of his voices:

“I was always fearful of rejection you see, I was very very fearful of being rejected by people. But the second Jesus said ‘it’s ok, this world rejected me. It hated me before it hated you. If you’re rejected by this world it knows you’re chosen by me’”

However, where Jeremy’s journey has been in a positive direction, David’s experience was different:
“I went through a few weeks of talking with Satan and then um also at the same time um I had voices coming from next door, my next door neighbours. And people across the road”

Illustrated here is that each individual participant has been on their own journey with their voices; forming relationships with them and noting changes in both the voices and themselves. Participants found their ability to reflect on this a helpful process as it supported their understanding of voices more clearly.

Subtheme 3: Connectedness vs disconnectedness

Much as each participant experienced a journey with their voices, the majority also described a recurring theme of feeling either connected or disconnected from their voices, regardless of understanding. Alice spoke about being “utterly dependent” on her voices in the absence of any other support. This offers a level of connectedness, however she goes on to state:

“I didn’t feel as though they were a part of me, I thought they were the ghost of my mum”

Being able to disconnect the voices and understanding them in this way may have been helpful for Alice. Whereas Louise, despite noticing changes in the sensory experience, she: “still [knew] they were my thoughts”. Acknowledging her voices in this way could have provided a sense of control.

Participants also commented not only on the connectedness or disconnectedness they had with their voices, but also in relation to others:

“because you know, it’s like the voices don’t understand that [other people don’t understand], and they should because I’m guessing they’re part of me, it’s like they don’t understand that unless it it’s such as you guys [mental health professionals] that
understand it, general public don’t understand it they think ‘Scott has gone barmy. He’s talking to people that are not there’”

Here, Scott illustrates an understanding that his voices are a part of him yet reflects that this can disconnect him from society as it results in him having to act differently depending on the audience. Participants were mixed in their levels of connectedness or disconnectedness with their voices, further illustrating the individualised sense-making structure that is adapted around this experience.

**Theme 5: Making sense**

*Subtheme 1: Difficult to express*

There was a sense among the participants that it was difficult to express their experience, particularly when asked questions they had not been required to articulate before. When asked to describe their experience of hearing voices, some participants gave conflicting accounts:

“[long pause] when um, the way they kind of developed it wasn’t so much that they just happened it was, how do you describe it? Well I know sometimes there’d be times where it did just kind of happen” (Louise)

Whilst others, like David, had a clear idea of the circumstances around the emergence of his voices, yet continued to struggle to articulate the experience:

“Um [pause] well [pause] around 3 years ago I got involved with a church. Um [pause]”

Here, David goes on to talk about how it was encouraged within his denomination of Christianity to converse with God and how he had “started um [pause] I started uh, trying to talk to God. I was getting replies”. Therefore, whilst he had a clear idea and was
able to make sense of his voices’ origins, the way this is expressed suggests uncertainty as well as difficulty revisiting where this began.

Where participants struggled to express their experience of hearing voices this appeared to impact how the experience was made sense of; whether participants had a clear idea of why they hear voices, or whether they were open to interpretations. There was a recurring theme, however, for participants wanting to articulate their experience yet concerns that they were not coming across well:

“Am I unusual?” (Scott)

“[pause] it’s bizarre. I know, [stutters]” (David)

Participants found it hard to talk about their experiences; whether this was driven by their sense-making or wanting to sound ‘normal’ to the researcher.

Subtheme 2: External to self

Some participants made sense of their voices by externalising their source. Jeremy does this by distinguishing the voices he hears:

“So I have to utterly distinguish between the old voices that I used to hear, which were a result of my mental illness. And the voices, the voice of God which I know I hear. Which comes from the Almighty”

He reports that he “decided to take medication ... overnight I recognised these voices had disappeared” which led to his understanding of having ‘mental illness’ voices, and hearing the voice of God. Distinguishing the two allows Jeremy to remain connected to his faith and the voice of God, and disconnect himself from the other voices he heard, allowing him to retain his sense of identity. Scott displays openness to interpretation, where he acknowledges that his voice could have a spiritual source:
“I don’t know whether it’s um a spirit that I hear, whether it’s physically my mind that’s become fragmented, or whether it’s um [pause] a spirit that I’m hearing, or a poltergeist or [pause] I don’t I don’t know what they genuinely are”

Though here it is clear that Scott does not have as strong a sense-making appraisal of his voices as Jeremy, it is apparent that he is open to interpretation and is balancing this between externalising “a spirit ... a poltergeist” and something more medical “my mind that’s become fragmented”. Jeremy expressed a stronger affiliation to his faith than Scott so it is plausible that he is less likely to consider alternatives when he is making sense of the experience. Similar to Scott, Louise described a genetic understanding for her voices:

“but I think there’s definitely something there genetically. It runs in the family because her mum was diagnosed ... paranoid psychosis”

She is able to logically make sense of her experience, whilst also acknowledging that there is a shared construct within her family. On the surface this presents as less comforting than understanding her experiences from a spiritual or religious source, yet Louise spoke with sincerity and ease about her experience, reflecting that she has made peace with this fact. Despite the differences in sense-making, the tendency for some participants to externalise their understanding of their voices’ origin may be a reflection of the unease experienced when attempting to acknowledge otherwise.

Subtheme 3: Influence of others

Finally, some participants also made reference to the influence that others had on how they made sense of their experiences. For some, this came from their families, the way that mental health was spoken about in the home and experienced by others:
“the thing is when you’ve, when you’ve got a parent like that, who can just spontaneously
go off on one ... but since like I’ve grown up, we’ve like talked a lot more about mental
health like a lot more maturely” (Louise)

Louise is able to reflect here that her earlier conversations about mental health influenced
her views of them, though these were then shaped by conversations later in life. Alice
described a similar experience. When asked what influenced her understanding of her
voices, she responded: “well my mum, I guess that’s the easiest part ... I was like
introduced to her voices from an early age”. There is a shared experience here of being
introduced to parental mental health at an early age, and both participants reflected that
this was not ideal.

Whilst some participants focus on familial influence, others place importance on the
influence of services. Whilst Alice describes how she used to make sense of her voices as
her mum had made sense of hers: “I used to feel the same way, that these were spirits
haunting me” she then describes how this changed:

“I mean obviously since having therapy I don’t really believe that anymore. Between the
ages of 13 and 21 that is what I believed”

She identifies a shift in her sense-making once she comes under mental health services.
Having earlier described that “the idea of them being spirits was comforting to me” it
appears that this has been altered. This was not a commonality among participant
accounts, however:

“[mental health service] have been quite good. They, they talk to you about stuff, well
[care-co] does, [care-co] talks to me about my faith and stuff like that” (David)
Here David is recounting that he understands his voices from a spiritual source, and that his mental health service has been a positive influence in maintaining this conversation and understanding.

As has been illustrated, making sense of experiences was not a linear process for the participants. It involves navigating their experience and forming a coherent narrative, whilst also attempting to understand whether this has occurred beyond their reach of impact (externally), and where others are impacting on this understanding. As identified earlier, the sense making process is an integral part of an individual’s journey with their voices and therefore influences on this are important to acknowledge.

**Discussion**

The current study represents, to the researcher’s knowledge, the first exploration of how spirituality may impact on the experience of voice hearing from a first-person account. It also provides new evidence for the cultural and subcultural differences in its understanding.

Participants identified conflicts in how they viewed themselves and how their experiences fitted with their religious or spiritual beliefs, as well as what is good and bad, ‘right’ or ‘wrong’. It seems that this represents Dennett’s (1991) proposition of a philosophical view of the self, stating it as the centre of narrative gravity. Views of the self are collated from social interactions, significant others and self-informed reflections (Jones and Coffey, 2012). It is suggested that these views, alongside memories of life events, assemble to form a coherent knowledge base about the self where all other aspects of the self are derived (Bentall, 2003). For example, when David refers to his
sentiments “from a Christian perspective” this infers he has an identity: ‘I am a Christian’.

When this self is challenged, therefore, an individual must either reassemble their view of the self or work out how the phenomenological experience best fits. Identities of those experiencing mental distress often result in re-formulation within a context of mental illness (Goffman, 1968). An individual, therefore, evolves from not only experiencing emotional and psychological responses to an experience, but also stigma and other social consequences (Jones and Coffey, 2012). This understanding of the self and acknowledgement of the impact that challenges to it pose, has implications that are pertinent regarding the support offered to individuals who hear voices. Jones and Coffey (2012) offer that a move beyond identification as ‘mentally unwell’ may be a further step in the process towards a coherent sense of self. This was seen here with Jeremy, who has been able to differentiate the voice of God from the voices of his mental illness. An effective utilisation of services, therefore, could be to encourage individuals to integrate their experience into their repertoire of self-identity, rather than focussing on symptom eradication. The present research recommends services reflect on, and re-evaluate, their approach to voice hearing with regards to this and ensure interventions correspond with this standing.

Participants also identified a struggle between initially needing to isolate themselves when they began to hear voices, and a need for belonging and to be ‘normal’. A shared perception here is of connectedness to others; be that to people or with their voices. This struggle among the participants is representative of Baumeister and Leary’s (1995) belongingness hypothesis. Here they suggested that the need to belong is a fundamental and powerful innate motivation in humans, where a failure to satisfy belongingness can
lead to social isolation (Baumeister & Leary, 1995; Mellor, Stokes, Firth, Hayashi, & Cummins, 2008). It is possible, therefore, that belonging encourages a feeling of social connectedness and can stave off loneliness. Research has outlined that an unmet need for belongingness can exert influence on subjective well-being, where loneliness has arisen as a result of this need being unmet (Mellor et al, 2008). This understanding of the need to belong has implications for how interventions for those hearing voices are addressed.

As above, services may be best placed not in symptom eradication, but in increasing individual’s sense of belonging and connectedness, whether this is with their voices or at a societal level. Liaising with Hearing Voices Groups (HVG; Dillon, & Longden, 2013) and the use psychological interventions such as voice dialogue (Stone & Stone, 2011) and voice relatedness (Hayward, 2003) are positive steps towards this approach and are in line with the findings. Evidence has shown that individuals hearing voices value the opportunity to meet others with similar experiences to their own (Ruddle, Mason, & Wykes, 2011); with participants in the present study also making reference to the value of shared experience.

The constructs of the self and identity, and the need for belonging are closely linked concepts. A main finding of the present study shows that both can be affected when an individual hears voices, and other research has shown that they can have a resultant psychological impact (e.g. Mellor et al, 2008). This can take the systemic form of stigma and other social consequences; or at an individual level, loneliness. Though none of the participants in the present study exhibited explicit loneliness, some did discuss the impact that stigma had had on them, particularly Alice: “People put a massive emphasis on being normal in society, and obviously if I’m hearing voices I’m not normal”. Mental health services play an important role in asking questions that can lead to a positive therapeutic relationship and side-effect, as opposed to imposing theory (Longden, Corstens, Escher,
& Romme, 2012). Services would benefit from taking this stance and reflecting on the impact of these constructs, taking an individual-led approach to interventions.

Consistencies can be drawn between the findings of previous literature and those in the present study. Descriptions of how voices are understood replicate Kalhovde et al’s (2014) findings, whereby the overall understanding from the accounts pertains to seeking belonging and leading ordinary lives with their voices. Parallels can also be drawn with Holt and Tickle’s (2015) findings where three overarching descriptive categories were found from participant accounts; the view of self, search for meaning, and explanations for voices. Pertinent here are the shared findings toward the negative view of the self, whereby participants describe the voices endorsing this view. Furthermore, both studies explore the sense-making process and factors which may emerge here. Of all six available qualitative studies on the experience of voice hearing, including the present research, it is clear that individuals hearing voices seek to develop frameworks to make sense of the experience (Fenekou and Georgaca, 2010; Holt and Tickle, 2015; Jones, Guy, & Ormrod, 2003; Kalhovde, Elstad, & Talseth, 2014; Minchin, 2017). The present findings support sense-making as part of the recovery process (Van der Hart et al, 1989) with the themes drawn from participant accounts aligning with Leamy and colleagues (2011) mental health recovery processes; empowerment, connectedness, identity, meaning in life and hope and optimism about the future.

Moreover, the present study accomplished what was intended; an exploration of the role of spirituality when individuals are making sense of voice hearing. The findings revealed that there exists a relationship between religion and spirituality, and the experience of hearing voices. It is clear that for the participants with arguably stronger disclosed
religious affiliations (as with Jeremy and David) their spiritual conflicts were more prominent. However, all participants described some connectedness with spirituality; whether this was helpful or otherwise. This highlights the importance of acknowledging the individual journeys encountered; assumptions could not and should not be made about how an individual arrives at a certain point in life. Within this study, each participant was faced with different struggles, barriers, and comforts, so despite the general themes drawing similarities across their stories, how they are distinguished is also pertinent.

Clinically this supports the case that professionals should work to understand the meanings that are ascribed to individual’s voices if they wish to promote their recovery (Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence, 2007) and alleviate any distress caused (Lakeman, 2001). Of importance is not to assume a lack of spiritual beliefs or sense-making system in the absence of religious identification. For example, in the present study Alice stated ‘no religion’ on the demographics form, however identified as spiritual throughout her account: “I think erm [pause] the whole idea of spirituality is how I’ve tried to normalise it”. This change can begin with the development of shared formulations and approaches to clinical practice that are informed by both the voice hearer and psychological models. Working in this way would be in keeping with psychological literature and guidelines stipulating the need and benefits of person-centred formulations (BPS, 2011; Johnstone & Dallos, 2013). Within this context, it would allow the accommodation of individual’s experiences of spirituality in relation to making sense of their voices, and what ‘recovery’ would look like to them, whilst also taking guidance from the structure of a psychological model. This recommendation is complemented by the accounts given by participants where mental health services are already displaying understanding of the impact and importance of religion and spirituality on these experiences, and within individual’s lives.
Methodological limitations

The small study population limits this research as IPA protocols recommend between six and eight participants, whereas this study only utilised five. This was in part due to recruitment opportunities and willingness to participate. As proposed by Malterud and colleagues (2015), however, the concept of information power is able to guide a sample size. The more information held by a sample that is in keeping with the study purpose, the lesser number of participants needed. Smith et al (2009) also note that within an IPA protocol depth is more highly regarded than breadth. Though rich data is provided from a purposely homogenous sample, generalisability of the findings to a wider population was not intended. Therefore, though the sample size limits the study’s findings, it is felt to be appropriate. All the included participants were White British, therefore experiences are likely to differ among individuals in other ethnic cultures (see Minchin, 2017).

The recruitment methods adopted for this study were open to bias. Whilst care co-ordinators were made aware of the inclusion and exclusion criteria, it became apparent that potential participants were being filtered and selected if they had expressed an interest in religion or spirituality previously, despite no requirement for affiliation being deemed necessary to the research. Some professionals also queried the meaning of spirituality, and it is considered that their understanding for its relevance in mental health care meant that some participants were not identified. This study also worked on a ‘self-selection’ basis, therefore opening itself to bias. For example, some participants began the interviews by talking about their religion or spirituality as this is how the study had been ‘sold’ to them. Considerations for whom the recruitment process may have missed and why the participants who took part volunteered their time should therefore be taken, and the findings interpreted with caution accordingly. Lastly, all participants were
recruited from within mental health services. Therefore, though all were well-versed in the understandings of professionals, and talking to them about their experiences, these conversations are likely to focus on risk and well-being, and not often providing a space to freely explore their experience and relationship with their voices. The unnatural nature of the interview structure may have felt unsettling therefore prompting the need to be understood. It cannot be ascertained with certainty that the theme throughout of participants’ desire to be understood was wholly resultant of their experiences.

**Future research**

Future research may begin to explore the roles of other cultures or constructs on how an individual makes sense of hearing voices. It would also be of interest to explore whether themes found in the present research are replicated in a non-clinical sample. This may help to reflect on the usefulness of distinct diagnostic categories for this experience where the level of self and identity related to being ‘mentally unwell’ may be minimised. It is possible that religion and spirituality may have a similar role for these individuals, though with different effects. Finally, it may be valuable to explore the attitudes of clinicians towards psychological interventions for hearing voices that are relationally based and to reflect whether more focus on increasing a sense of belonging and integrating experiences into their identity is related to better outcomes or recovery. This could begin first by exploring clinician’s own experiences and understandings of belongingness.
Conclusions

The present research provides preliminary evidence for the possibility of religion and spirituality being positive coping resources for individuals, as well as indicating that it can also form as a powerful basis for self and identity conflicts. The findings echo those of Minchin (2017) that encourages clinicians to value the expertise that service users bring to a clinical setting (Bassat & Sickley, 2010). Remaining a curious-observer will develop understanding of how an individual may make sense of their voices within a spiritual context, or indeed any social, cultural, or political context. As far as the authors are aware, this study is the first to examine the role of spirituality within the sense-making process of the voice hearing experience, and therefore holds pertinent implications for mental health services.
References


British Psychological Society. (2014). *Understanding Psychosis and Schizophrenia: Why people sometimes hear voices, believe things that others find strange, or appear*
out of touch with reality, and what can help. Leicester: British Psychological Society.


"Paranormal Studies, 29(4)."

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
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 online 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. Authors can make use of Elsevier's Illustration and Enhancement service to ensure the best presentation of their images and in accordance with all technical requirements: Illustration Service.

*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.

**Electronic artwork**

**General points**
- 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.

A detailed guide on electronic artwork is available. You are urged to visit this site; some excerpts from the detailed information are given here. **Formats**
If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format. Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):

EPS (or PDF): Vector drawings, embed all used fonts.
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.
TIFF (or JPEG): Combinations bitmapped line/halftone (color or grayscale), keep to a minimum of 500 dpi.

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.

Color artwork
Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article. Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

Figure captions
Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (not on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables
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.

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
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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.

Web references
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.

References in a special issue
Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference management software
Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley and Zotero, as well as EndNote. Using the word processor plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style.

If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:
http://open.mendeley.com/use-citation-style/clinical-psychology-review

When preparing your manuscript, you will then be able to select this style using the Mendeley plugins for Microsoft Word or LibreOffice.

Reference style
References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. References should be formatted with a hanging indent (i.e., the first line of each reference is flush left while the subsequent lines are indented).


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Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article are strongly encouraged to include links to these within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the files in one of our recommended file formats with a preferred maximum size of 150 MB. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including ScienceDirect. Please supply 'stills' with your files: you can choose any frame from the video or animation or make a separate image. These will be used instead of standard icons and will personalize the link to your video data. For more detailed instructions please visit our video instruction pages. Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic and the print version for the portions of the article that refer to this content.

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**3D neuroimaging**

You can enrich your online articles by providing 3D neuroimaging data in NIfTI format. This will be visualized for readers using the interactive viewer embedded within your article, and will enable them to: browse through available neuroimaging datasets; zoom, rotate and pan the 3D brain reconstruction; cut through the volume; change opacity and color mapping; switch between 3D and 2D projected views; and download the data. The viewer supports both single (.nii) and dual (.hdr and .img) NIfTI file formats. Recommended size of a single uncompressed dataset is maximum 150 MB. Multiple datasets can be submitted. Each dataset will have to be zipped and uploaded to the online submission system via the '3D neuroimaging data' submission category. Please provide a short informative description for each dataset by filling in the 'Description' field when uploading a dataset. Note: all datasets will be available for downloading from the online article on ScienceDirect. If you have concerns about your data being downloadable, please provide a video instead.
Submission checklist

The following list will be useful during the final checking of an article prior to sending it to the journal for review. Please consult this Guide for Authors for further details of any item.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:
- E-mail address
- Full postal address

All necessary files have been uploaded, and contain:
- Keywords
- All figure captions
- All tables (including title, description, footnotes)

Further considerations:
- Manuscript has been 'spell-checked' and 'grammar-checked'
- References are in the correct format for this journal
- All references mentioned in the Reference list are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Internet)
- Printed version of figures (if applicable) in color or black-and-white
  - Indicate clearly whether or not color or black-and-white in print is required. For any further information please visit our Support Center.
## Appendix B. Data Extraction Form

<table>
<thead>
<tr>
<th>General</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td></td>
</tr>
<tr>
<td>Year of publication</td>
<td></td>
</tr>
<tr>
<td>Title of study</td>
<td></td>
</tr>
<tr>
<td>Peer Reviewed?</td>
<td></td>
</tr>
<tr>
<td>Research aims</td>
<td></td>
</tr>
<tr>
<td>Research design</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td></td>
</tr>
<tr>
<td>Sample Size</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/title</td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td></td>
</tr>
<tr>
<td>Mode of delivery (how? who?)</td>
<td></td>
</tr>
<tr>
<td>Description of content</td>
<td></td>
</tr>
<tr>
<td>Control/comparison</td>
<td></td>
</tr>
<tr>
<td>Randomised? (how?)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure of spirituality/religion</td>
<td></td>
</tr>
<tr>
<td>Other outcomes (measure of MH?)</td>
<td></td>
</tr>
<tr>
<td>When measured</td>
<td></td>
</tr>
<tr>
<td>Statistical analysis</td>
<td></td>
</tr>
<tr>
<td>Main findings</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conclusion</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Of author(s)</td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>Quality rating</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Quality Assessment Checklist

Checklist items are worded so that 1 of 5 responses is possible:

| ++  | Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimize the risk of bias. |
| +   | Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design. |
| -   | Should be reserved for those aspects of the study design in which significant sources of bias may persist. |
| Not reported (NR) | Should be reserved for those aspects in which the study under review fails to report how they have (or might have) been considered. |
| Not applicable (NA) | Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case control studies). |

Methods for the development of NICE public health guidance (third edition) (PMG4)

Checklist

Study identification: (Include full citation details)

Study design:
Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design

Guidance topic:

Assessed by:

Section 1: Population

1.1 Is the source population or source area well described?
Was the country (e.g. developed or non-developed, type of healthcare system), setting (primary schools, community centres etc.), location (urban, rural), population demographics etc. adequately described?

1.2 Is the eligible population or area representative of the source population or area?
Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)?
Was the eligible population representative of the source? Were important groups under-represented?

1.3 Do the selected participants or areas represent the eligible population or area?
Was the method of selection of participants from the eligible population well described?
What % of selected individuals or clusters agreed to participate? Were there any sources of bias?
Were the inclusion or exclusion criteria explicit and appropriate?

Section 2: Method of allocation to intervention (or comparison)
<table>
<thead>
<tr>
<th>2.1 Allocation to intervention (or comparison). How was selection bias minimised?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was allocation to exposure and comparison randomised? Was it truly random ++ or pseudo-randomised + (e.g. consecutive admissions)?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>If not randomised, was significant confounding likely (-) or not (+)?</td>
<td>-</td>
<td>NR</td>
</tr>
<tr>
<td>If a cross-over, was order of intervention randomised?</td>
<td>NR</td>
<td>NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.2 Were interventions (and comparisons) well described and appropriate?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were interventions and comparisons described in sufficient detail (i.e. enough for study to be replicated)?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Was comparisons appropriate (e.g. usual practice rather than no intervention)?</td>
<td>-</td>
<td>NR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.3 Was the allocation concealed?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could the person(s) determining allocation of participants or clusters to intervention or comparison groups have influenced the allocation?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Adequate allocation concealment (+++) would include centralised allocation or computerised allocation systems.</td>
<td>-</td>
<td>NR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.4 Were participants or investigators blind to exposure and comparison?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were participants and investigators – those delivering or assessing the intervention kept blind to intervention allocation? (Triple or double blinding score ++)?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>If lack of blinding is likely to cause important bias, score -.</td>
<td>-</td>
<td>NR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.5 Was the exposure to the intervention and comparison adequate?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is reduced exposure to intervention or control related to the intervention (e.g. adverse effects leading to reduced compliance) or fidelity of implementation (e.g. reduced adherence to protocol)?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Was lack of exposure sufficient to cause important bias?</td>
<td>-</td>
<td>NR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.6 Was contamination acceptably low?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did any in the comparison group receive the intervention or vice versa?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>If so, was it sufficient to cause important bias?</td>
<td>-</td>
<td>NR</td>
</tr>
<tr>
<td>If a cross-over trial, was there a sufficient wash-out period between interventions?</td>
<td>NR</td>
<td>NA</td>
</tr>
<tr>
<td>2.7 Were other interventions similar in both groups?</td>
<td>++</td>
<td>Comments:</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----</td>
<td>-----------</td>
</tr>
<tr>
<td>Did either group receive additional interventions or have services provided in a different manner?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Were the groups treated equally by researchers or other professionals?</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td>Was this sufficient to cause important bias?</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.8 Were all participants accounted for at study conclusion?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were those lost-to-follow-up (i.e. dropped or lost pre-, during or post-intervention) acceptably low (i.e. typically &lt;20%)?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Did the proportion dropped differ by group? For example, were drop-outs related to the adverse effects of the intervention?</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.9 Did the setting reflect usual UK practice?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the setting in which the intervention or comparison was delivered differ significantly from usual practice in the UK? For example, did participants receive intervention (or comparison) condition in a hospital rather than a community-based setting?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.10 Did the intervention or control comparison reflect usual UK practice?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the intervention or comparison differ significantly from usual practice in the UK? For example, did participants receive intervention (or comparison) delivered by specialists rather than GPs? Were participants monitored more closely?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

**Section 3: Outcomes**

<table>
<thead>
<tr>
<th>3.1 Were outcome measures reliable?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking -)?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)?</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td>Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>3.2 Were all outcome measurements complete?</td>
<td>++</td>
<td>Comments:</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----</td>
<td>-----------</td>
</tr>
<tr>
<td>Were all or most study participants who met the defined study outcome definitions likely to have been identified?</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.3 Were all important outcomes assessed?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were all important benefits and harms assessed?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.4 Were outcomes relevant?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where surrogate outcome measures were used, did they measure what they set out to measure? (e.g. a study to assess impact on physical activity assesses gym membership – a potentially objective outcome measure – but is it a reliable predictor of physical activity?)</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.5 Were there similar follow-up times in exposure and comparison groups?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.6 Was follow-up time meaningful?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was follow-up long enough to assess long-term benefits or harms?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Was it too long, e.g. participants lost to follow-up?</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

Section 4: Analyses
<table>
<thead>
<tr>
<th>Section</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Were exposure and comparison groups similar at baseline? If not, were these adjusted?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Were there any differences between groups in important confounders at baseline?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>If so, were these adjusted for in the analyses (e.g. multivariate analyses or stratification)?</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Were there likely to be any residual differences of relevance?</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>4.2 Was intention to treat (ITT) analysis conducted?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Were all participants (including those that dropped out or did not fully complete the intervention course) analysed in the groups (i.e. intervention or comparison) to which they were originally allocated?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>4.3 Was the study sufficiently powered to detect an intervention effect (if one exists)?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>A power of 0.8 (that is, it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard.</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>4.4 Were the estimates of effect size given or calculable?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Were effect estimates (e.g. relative risks, absolute risks) given or possible to calculate?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>4.5 Were the analytical methods appropriate?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Were important differences in follow-up time and likely confounders adjusted for?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>If a cluster design, were analyses of sample size (and power), and effect size performed on clusters (and not individuals)?</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Were subgroup analyses pre-specified?</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
### Methods for the development of NICE public health guidance (third edition) (PMG4)

| 4.6 Was the precision of intervention effects given or calculable? Were they meaningful? | ++ |
| Were confidence intervals or p values for effect estimates given or possible to calculate? | + |
| Were CI’s wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered? | - |

| Comments: |
| NR |
| NA |

#### Section 5: Summary

| 5.1 Are the study results internally valid (i.e. unbiased)? | ++ |
| How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? | + |
| Were there significant flaws in the study design? | - |

| Comments: |
| |

| 5.2 Are the findings generalisable to the source population (i.e. externally valid)? | ++ |
| Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications. | + |

| Comments: |
| |

---

# Appendix D: Quality assessment scores

<table>
<thead>
<tr>
<th>Study</th>
<th>Checklist item score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Koenig et al (2015)</td>
<td>++ ++ + ++ + + ++ ++ ++ ++ + ++ ++ ++ ++ ++ ++ ++ ++ ++ ++ ++ + ++ + ++ + ++ + ++ + 63</td>
</tr>
<tr>
<td>Koenig et al (2015a)</td>
<td>- - - + ++ - - ++ ++ + NR + + ++ ++ + ++ ++ ++ ++ NR + + ++ ++ + ++ + + + 48</td>
</tr>
<tr>
<td>Koszycki et al (2010)</td>
<td>+ + + + ++ ++ + ++ ++ ++ + ++ ++ + ++ ++ ++ ++ ++ ++ NR ++ ++ ++ + ++ + 52</td>
</tr>
<tr>
<td>Pearce &amp; Koenig (2016)</td>
<td>++ ++ + + ++ - - ++ ++ + ++ ++ ++ ++ ++ + ++ + + ++ + - - ++ ++ ++ + 48</td>
</tr>
<tr>
<td>Propst et al (1992)</td>
<td>- NR NR ++ ++ - - ++ ++ ++ ++ + + ++ NR ++ ++ ++ ++ NR NR NR ++ NR + + 48</td>
</tr>
<tr>
<td>Richards et al (2006)</td>
<td>- + + ++ + - - ++ ++ - NR + + ++ NR ++ ++ NR NR ++ NR NR ++ ++ ++ + + + 41</td>
</tr>
<tr>
<td>Rosmarin et al (2010)</td>
<td>+ + + ++ ++ ++ NR ++ ++ + + + + ++ + ++ + ++ ++ + ++ ++ + ++ ++ ++ + 52</td>
</tr>
</tbody>
</table>

| Total percentage (%) ++       | 25 25 0 63 75 25 0 100 100 50 38 25 0 63 50 50 100 75 88 88 25 50 38 100 75 63 25 |
Appendix E: Submission guidelines for *Journal of Cross-Cultural Psychology*

*Journal of Cross-Cultural Psychology (JCCP)* publishes material in three categories: (1) regular, unsolicited manuscripts, (2) brief reports, and (3) special issues. Summary details of each category are as follows:

1. Regular, Unsolicited Manuscripts. This is JCCP’s main emphasis. See *Aims and Scope* for a detailed description of appropriate manuscripts.

Manuscripts should be submitted electronically to [http://mc.manuscriptcentral.com/jccp](http://mc.manuscriptcentral.com/jccp). Authors will be required to set up an online account on the SageTrack system powered by ScholarOne. Manuscripts will be sent out anonymously for editorial evaluation. Obtaining permission for any quoted or reprinted material that requires permission is the responsibility of the author. Submission of a manuscript implies commitment to publish in the journal. Authors submitting manuscripts to the journal should not simultaneously submit them to another journal, nor should manuscripts have been published elsewhere in substantially similar form or with substantially similar content. Authors in doubt about what constitutes prior publication should consult the Editor.

Manuscript length should normally be 15 to 35 double-spaced, typewritten pages. Longer papers will be considered and published if they meet the above criteria. Manuscripts should be prepared according to the most recent edition of the American Psychological Association Publication Manual. Manuscripts are reviewed by the Editorial Advisory Board. Allow up to 3 months for a publication decision and up to 1 year for publication.

2. Brief Reports. Accepted Brief Reports should be no more than 10 double-spaced manuscript pages long, including title page, references and any tables.

3. Special Issues. An important part of JCCP's publication policy is the periodic publication of special issues or special sections of regular issues. Current needs, emerging trends, and readership interest guide the publication of material in this category. Ideas or suggestions for special issues or special sections should be discussed with Walter J. Lonner ([Walter.Lonner@wwu.edu](mailto:Walter.Lonner@wwu.edu)), Founding and Special Issues Editor, or other members of the Editorial Advisory Board, especially current Editor, Deborah L. Best ([best@wfu.edu](mailto:best@wfu.edu)).

English language editing services

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal’s specifications should consider using the services offered by SAGE Language Services. Visit SAGE Language Services on our Journal Author Gateway for further information. Here is the link:

Title: Understanding the role of spirituality when making sense of hearing voices

We would like to invite you to take part in our research study which is looking at how an individual's spirituality may have impacted how they made sense of hearing voices that no-one else can hear. Before you decide if you want to participate, we would like you to understand why this research is being done. We would also like you to understand what it will involve for you if you decide to participate. You can talk to others if you would like before you decide if you want to take part. The researcher will answer any questions you may have.

What is the purpose of the study?
We know very little from first-hand accounts of what it is like to hear voices that no-one else can hear, and we know even less about how people make sense of their voices. There is also an increasing interest within psychological and mental health literature on the impact of an individual's spirituality on how they make sense of experiences. The purpose of this study is therefore to understand if people’s experience of voice hearing is influenced by their spirituality. I hope that this study will help us to understand more about these experiences which will hopefully be helpful in improving treatment plans within services and reduce the stigma that hearing voices currently within society. It is hoped that the results of this study will encourage and add to the argument that hearing voices that no-one else can hear is a meaningful human experience.

Why have I been invited?
This information is given to people who hear voices that no-one else can hear, and are over the age of 18. Staff members at your service will have given this information sheet to people who may fulfil this criteria to take part in the study as they may be interested in participating.

Do I have to take part?
No, participation is completely voluntary. If you decide to take part you will be asked to sign a consent form to indicate that you agree to take part. You are free to withdraw from the study up to the point where the study results are analysed and written up. Your decision will not affect your care or your legal rights.
What will happen if I decide to take part?
If you agree to take part please complete the details at the bottom of this information sheet and leave it with a member of staff. Then you will be contacted by the researcher to arrange a meeting at a convenient place and time. You will have a conversation with the researcher which will last around 90 minutes. The researcher, who is a trainee clinical psychologist, will be asking you some questions about your experience of hearing voices and any impact that spirituality may have had on this. This discussion will be audiotaped. There are no right or wrong answers and we are only interested in your experience, your beliefs and your opinions on hearing voices.

What are the possible disadvantages and risks of taking part?
Participating in this study will require around 90 minutes of your time and this may be inconvenient for you. Some people may experience emotional distress when they talk about their experience of hearing voices because it may bring to mind difficult issues and struggles associated with this experience. If this happens to you the researcher will offer support and provide you with some information on additional support after the interview.

What are the possible benefits of taking part?
We cannot promise that you will have any direct benefits from taking part in the study. However, services have often neglected the role of spirituality in people’s lives and how this might provide a way for people to make sense of voice hearing. It is hoped that this research will help us to understand the role of spirituality in people’s sense-making and it may also help to improve the support that can be offered by relevant services.

What if there is a problem?
If you have a concern about the study you can contact the researcher or their supervisor who will do their best to answer your questions.

Will my taking part in this study be kept confidential?
The interviews will be audiotaped but only the researcher will know who you are. The audio tape will be transcribed and anonymised at this time. At this point the transcripts will be given a code. Any quotes use in dissemination or published reports will be kept anonymous. Upon transcription of the audio recordings, these will be confidentially destroyed, and the transcriptions will be stored securely in a locked filing cabinet at the University of Hull. Data will be stored for 10 years, at which point it will be confidentially destroyed. The only time the information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm, or if you disclose any criminal intention. If this happens during the interview the researcher will need to contact the appropriate authorities to ensure that you and other people are safe. At this point the researcher will try to discuss the disclosure with you.
What happens to the results of the study?
After the study is completed if you wish you will be given written feedback about
the results of the study. We will also invite you to make comments on the results
if you wish but this will be completely voluntary. The results will be written in an
anonymised report that will be submitted to the university in partial fulfilment of
my academic degree. The results will be disseminated to participating services
and Hearing Voices groups. The report will also be submitted for publication in
an academic journal and maybe presented at conferences. Some direct quotes
from your interview may be used in the write up. Your personal details and any
identifiable information 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
responsible individuals from the University of Hull of from regulatory authorities
to ensure that appropriate guidance was followed by the researcher.

Who has reviewed the study?
The study was 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.

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

Yours sincerely

Sophie Lewis
Trainee Clinical Psychologist

Supervised by

Dr Chris Sanderson
Clinical Psychologist

Further information and contact details:

Sophie Lewis
The Department of Psychological Health and Wellbeing
Aire Building
University of Hull
Cottingham Road
Hull
HU6 7RX
Email: S.H.Lewis@2011.hull.ac.uk

If you are interested to take part in this 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 for your interest!
Appendix G: Participant consent form

Consent Form

Title of Project: Understanding the role of spirituality when making sense of hearing voices

Name of Researcher:

Please initial boxes

1. I confirm that I have read and understand the information sheet dated (24/10/16 version 1.5) 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.

Once completed: original to be kept by the participant and a copy to be kept by the researcher

Name of participant __________________________ Date __________________________ Signature __________________________

Name of researcher __________________________ Date __________________________ Signature __________________________
Appendix H: Participant demographics form

Demographic Information

INFORMATION ABOUT YOU

Please complete the following:

Participant number: ........................................

1. Age: ........................................

2. Gender: Male ☐ Female ☐ (please tick ☑)

3. Ethnicity:
   ☐ White British
   ☐ Mixed/multiple ethnic groups (please specify)
   ..........................................................
   ☐ Asian/Asian British
   ☐ Black/African/Caribbean/Black British
   ☐ Other (please specify)
   ..........................................................

4. Religion:
   ☐ None ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
   ☐ Buddhist ☐ Hindu
   ☐ Jewish ☐ Muslim
   ☐ Sikh ☐ Other (please specify)
   ..........................................................

Humber NHS Foundation Trust

UNIVERSITY OF Hull
5. **When did you first begin to hear voices?**

- □ Less than a year ago
- □ 1 year ago
- □ 2 years ago
- □ 3 years ago

If longer than 3 years ago, please specify a timeframe below
Appendix I: Ethical approval documentation

REMOVED FOR HARD BINDING
Appendix J: Interview schedule

Interview Schedule

I’m interested in people’s personal experience of their voice hearing and how this has affected them.

Q1. Tell me about your experience of hearing voices.
   Prompt: when did it first happen, what did you notice first? What did you think was happening, How would you describe the experience? How did you feel?

Q2. Can you describe how you understand your voices?
   Prompt: How do you explain your voices? What does the experience mean to you?

Q3. How does this understanding affect your experience of hearing voices
   Possible prompts: Making it better/worse, meaning making

Q4. What, if anything, has influenced your understanding of your voices?
   Possible prompts: Changes over time, learning

Q4. What is your experience or understanding of spirituality?
   Prompt: what does it mean to you, how does it feature in your life, if at all (this might be family/culture/community)

Q5. What impact, if any, could spirituality have had on understanding your voices?
   Possible prompts: This isn’t to say that it has had an impact, but more of a hypothetical

Q6. How have you found this interview?
   Possible prompts: In relation to hearing voices
Additional support and information

There are several Talking Heads groups that are offered by the Humber NHS Foundation Trust in the Hull and East Riding area; people can be formally referred to the group, but self-referrals are also accepted. These are groups for people that hear voices that no-one else can hear, and often people find talking with others who have similar experiences to be helpful; providing a sense of community and ways of coping.

http://www.humber.nhs.uk/services/talkingheads

Telephone: 0114 271 8210

The Hearing Voices Network also offers some information and advice regarding hearing voices that others can’t hear on its website:

http://www.hearing-voices.org/

Should you need any additional support regarding your experiences, you can contact the Samaritans on:

01482 323456

If there are any specific issues that have been raised as a result of taking part in this study then you can contact the researcher at:

S.H.Lewis@2011.hull.ac.uk

You can also seek advice from your GP, or from your care co-ordinator should you be involved with a service.
Appendix L: Example of data analysis

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Comments</th>
<th>Emergent themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher: So you said sometimes the voice of the enemy comes back a little bit. Do you think that you, because it sounds like you practice your faith quite a lot, that you pray a lot and you go to study group, do you think that helps you to cope with it or live with it in a different way than you did before?</td>
<td>Jeremy: Um [pause] I think when I first became a Christian, I isolated myself. I read the Bible all the time. I was practicing my faith and I didn’t have that level of trust within human beings which I now have. It’s honestly, spending... I’ve never been as welcome as I have within a church. There aren’t a lot of young people in the church these days, so I’ve met so many loving, caring, honest people who without the Holy Spirit living within them, then it’s just like me. The example of me. How cold my heart used to be before the Holy Spirit entered me. And I, on the night I asked Jesus into my heart, I saw loads of flashing lights, loads of flashing lights. I’ve got loads of stories like this you know. But in terms on what my activity does today, how did that help me with me mental illness? I’m gonna have to say that my mental illness is well and truly buried.</td>
<td>Isolated self away as penance? Needed to study the Bible for acceptance and be worthy of Church – belonging. Trust in voices not people</td>
</tr>
<tr>
<td>R: Yeah.</td>
<td>No longer mentally ill – evident from the things he does/voices he hears/lack of evil voice Able to differentiate the voices – this was when I was unwell and this is the voice of God</td>
<td>Conflicts Isolation vs belonging</td>
</tr>
<tr>
<td></td>
<td>Paid off to isolate self – positives in penance Sense of belonging by demographic</td>
<td>Belongs Journey with his faith</td>
</tr>
<tr>
<td></td>
<td>Cannot bear thinking about life without the Holy Spirit – isn’t worth thinking about. Grateful for the journey he’s been on and for the chance he’s been given</td>
<td>Change (positive)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments</th>
<th>Emergent themes</th>
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<tbody>
<tr>
<td></td>
<td>Conflicts</td>
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<td></td>
<td>Isolation vs belonging</td>
</tr>
<tr>
<td></td>
<td>Belongs</td>
</tr>
<tr>
<td></td>
<td>Journey with his faith</td>
</tr>
<tr>
<td></td>
<td>Change (positive)</td>
</tr>
</tbody>
</table>
J: And what I practice today as a believer in Jesus is purely based upon what he’s done for my life and who He is. And where I’m gonna spend eternity and how I can help people you see. I never wanted to hurt anyone in my life. I used to fall over a bit when I was drinking, but I never wanted to offend anyone I never wanted to cause offence. I was always fearful of rejection you see, I was very very fearful of being rejected by people. But the second Jesus said ‘it’s ok, this world rejected me. It hated me before it hated you. If you’re rejected by this world it knows you’re chosen by me’. So I’m not over the world basically. Um [pause] so my fear of rejection [clicks fingers] just vanished. It just vanished into thin air. Obviously you still get human fears, like we all need acceptance, promotion, in different aspects in our life. But I’ve got a purpose now. I’ve got a purpose in my life. I’ve got acceptance from the God who made everything.

R: Yeah

J: I’ve got redemption. I’ve got peace. I’ve got joy. And I’ve got love. And that’s what God is at the end of the day God is love.

<table>
<thead>
<tr>
<th>Changes made based on help</th>
<th>doesn’t take full credit. Externalising. A lot to be grateful for since finding faith</th>
<th>Emotionally? Physically?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>always been kind and caring of others – faith pulled this out of him?</td>
<td>Rejection of peers – need to belong</td>
</tr>
<tr>
<td></td>
<td>Aligning self with Jesus; sense of shared experience and understanding. Holds Jesus in high regard therefore motivation to continue. Feeling special?</td>
<td>Need to be accepted by someone and understood to get over fears</td>
</tr>
<tr>
<td></td>
<td>Separating human fears from the spiritual – sentiment to how religious he is and how important it is</td>
<td>Purpose in life – resources at hand to take on hardship</td>
</tr>
<tr>
<td></td>
<td>Ultimate acceptance</td>
<td>Forgiveness from God = second chance; with forgiveness comes joy, love etc. Positive appraisal of religion</td>
</tr>
</tbody>
</table>

Gratitude?

Contextualising his experience

Sense of belonging

Shard experience

Finally feeling understood

Belonging with Church

Second chances
Appendix M: Example of themes and supporting quotation data

**Superordinate theme: Relationships with others**

<table>
<thead>
<tr>
<th>Subordinate themes</th>
<th>Examples of supporting quotation data</th>
</tr>
</thead>
</table>
| Isolation vs belonging | *Alice*  
“Yeah, because I was utterly dependent on them because I didn’t feel like I had anyone else” (1:23)  
“because I had the voices… so because I didn’t really get along with anyone anyway and at dinner times I would sit by myself… I would basically just shut myself away from the other pupils” (1:43)  
[about why she hasn’t disclosed voice hearing] “they would sort of mock her and laugh at her because obviously the general feeling was that schizophrenics were dangerous, they were nutters” (1:55)  
“I was afraid of that [mocking of mum] happening to me, that I would become the neighbourhood [sic] happening to me, that I would become the neighbourhood [sic]” (1:64) |

| Jeremy |  
“I think most Christians, I don’t think I’ve ever met a Christian that doesn’t acknowledge the fact that they talk to God and God talks back” (2:76)  
“Um [pause] I think when I first became a Christian, I isolated myself. I read the Bible all the time. I was practising my faith and I didn’t have that level of trust within human beings which I now have. It’s honestly… I’ve never been as welcome as I have within a church” (2:134)  
“I was always fearful of rejection you see, I was very very fearful of being rejected by people. But the second Jesus said ‘it’s ok, this world rejected me. It hated me before it hated you. If you’re rejected by this world it knows you’re chosen by me’” (2:150) |

| Louise |  
“everyone was kind of like of the same class, if you get what I mean. Like some people were better off but they still had that mentality of like, I dunno, we all still kind of had the same mentality” (3:200)  
“yeah and the church is like, it kind of goes with the school, and it was like really religious and I wasn’t religious at all” (3:217) |

| David |  
“Um [pause] because I became very um [pause] very introvert and unable to express myself. I felt anxious being around people for years, and built up to this. Um, I sort of isolated myself from people as well, I became isolated but um [pause] in terms of religion” (4:85)  
“I still pray, but I’m not going to church. I’m not going to church” (4:97)  
“So [pause] so yeah, in my denomination, like speaking to voices was commonplace” (4:153) |

| Scott |  
“I was sort of closed in a bit into me shell and didn’t want to talk about it or admit to it.” (5:17)  
“I was, well I was in this house, I was just going about my day to day whatever I do, back then I was working because um because it was prior having me bad back so I was going to work” (5:78) |
<table>
<thead>
<tr>
<th>Disclosure &amp; seeking help</th>
<th>Alice</th>
</tr>
</thead>
<tbody>
<tr>
<td>“So that’s [pause] I wasn’t really that alarmed to begin with and I guess that’s why I kind of delayed in telling anybody because to me it was all I’d ever known” (1:185)</td>
<td></td>
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<table>
<thead>
<tr>
<th>Louise</th>
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<tbody>
<tr>
<td>“her father would be able to cope with it, uh, and you know kind of give her that support that she needed, when and where he could” (3:42)</td>
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<table>
<thead>
<tr>
<th>David</th>
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<tbody>
<tr>
<td>“and he [God] was giving me really good advice. He’s telling me to, I don’t, really good advice in day to day, you know” (4:14)</td>
</tr>
<tr>
<td>“they [voices] got me thinking about my past. So I’d go through my past, and at first I thought they were giving me sort of therapy, going through all my past, like my traumatic experiences in life” (4:36)</td>
</tr>
<tr>
<td>“People can be [stammers] you can’t open up about that sort of stuff to many people” (4:134)</td>
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<tr>
<th>Scott</th>
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<tr>
<td>“I didn’t do owt about it because at first I thought ‘ugh I’m going crazy, this can’t be real, this doesn’t happen to me’. So at first I thought I was going mad” (5:15)</td>
</tr>
<tr>
<td>“I ended up confiding in a couple of people I trusted and they says ‘you know you can go to the doctor about that, they’ll just medicate you’” (5:19)</td>
</tr>
<tr>
<td>“It wasn’t until then [seeking help] that I started to make any sense of it because to me, I was going mad. I was going out me mind, you know. Because it’s not normal to have voices because I didn’t know any, any different” (5:104)</td>
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<table>
<thead>
<tr>
<th>Understanding of others (or lack of)</th>
<th>Alice</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I couldn’t talk to my friends because they all had parents and they didn’t really [pause]” (1:123)</td>
<td></td>
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<tr>
<td>“and she stopped doing this running away because she no longer had her mum around to verbally abuse her and things like that” (1:172)</td>
<td></td>
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<tr>
<td>“I haven’t really spoken to other people because I have a feeling, if, say if someone was Catholic or something like that, I have a feeling they’d be very confused by this logic” (1:228)</td>
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<table>
<thead>
<tr>
<th>Jeremy</th>
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<tr>
<td>“I haven’t managed to tell you everything, I told her everything Jesus has done in my life from day one. She’s never asked me not to talk about my faith” (2:179)</td>
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<tr>
<th>Louise</th>
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<tr>
<td>“she’s a lot better than she used to be, um, because, yeah what I meant by like um, ‘as I grew up home life got more stressful’, was my mum’s always been a self-harmer She first self-harmed when she was five years old and she told me about it I think, she she’s always been, I think, um [pause] look back on it now, maybe too open” (3:104)</td>
</tr>
<tr>
<td>“Are you from [location]?” “Do you know like the reputation of some of the schools and some of the areas?” (3:185)</td>
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<tr>
<th>David</th>
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<tbody>
<tr>
<td>“Did you used to be a Christian yourself” (4:122)</td>
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</table>
Scott
“if I did [go to Church] they’d probably all sit round me and pray for me and go you know ‘[speaks gibberish] I cast out the demons’ because they don’t understand” (5:206)
“because you know, it’s like the voices don’t understand that, and they should because I’m guessing they’re part of me, it’s like they don’t understand that unless it it’s such as you guys [points] that understand it, general public don’t understand it they think ‘Scott has gone barmy. He’s talking to people that are not there’” (5:117)
“Does that make any sense? … Alright good, [laughs] that’s a relief” (5:158)
Appendix N: Epistemological statement

Upon reviewing the literature into the experience of hearing voices, there was no doubt that my research would develop under a qualitative framework. Throughout my education and experiences, research has been sold as testable, measurable, and scientific; something that I have always queried. My own biases toward a more subjective truth therefore undoubtedly informed my desire to conduct research qualitatively. However, being a flexible researcher, making use of scientific measures to inform subjective accounts of experience was considered (e.g. Beliefs about Voices Questionnaire, BAWQ; Chadwick, Lees, & Birchwood). That approach did not feel appropriate and I felt that only an exploratory study could adequately capture individual’s experiences. Unsurprisingly to me, research has found this is best done with qualitative study (Willig, 2001). This statement therefore acknowledges the underlying assumptions of the present research, outlining the epistemological stance taken throughout and providing my own expectations going into this research.

Two main qualitative methodologies were reviewed, Discourse Analysis (DA; Potter, 2003) and Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009), to determine whether their ideologies corresponded with my intentions for this research. DA was not deemed suitable as one of its primary roles is exploring the role of language in the constructions of social reality. It was felt that the current study would benefit more from a thematic approach over a language-focused methodology. The ties that DA holds within social constructionism were kept in mind however, and shall be discussed with regards to the present research.

Whereas DA places focus on the linguistic and discursive properties of language, IPA focuses on exploring how individuals make sense of their world and the meanings concluded from experiences (Smith et al, 2009). In adopting an IPA methodology the researcher commits themselves to exploring and describing how individuals make sense of their experiences as well as the processes along the way (Smith & Osborn, 2008). It is assumed that such subjective experiences are accessible through reflection, centred on discussion of the ‘phenomena’ in semi-structured interviews (Larkin, Watts, & Clifton,
The former ‘interpretive’ component of IPA refers to the hermeneutic stance that sense-making of an experience is affected by the subjective interpretations made by those viewing them (Smith, Flowers, & Larkin, 2009). These interpretations can be shaped, for example by culture, based upon the idiographic experiences of the interpreter. A distinct interest in this stance, therefore, is in phenomenology not as a philosophy, but rather as a unique way of understanding human existence (Kafle, 2013). The hermeneutic stance consequently has a double operative; the researcher interprets and ascribes meaning to the participant’s account, where the account told already carries the participant’s subjective meaning of it. In sum, IPA functions by giving a voice to individual’s experiences, then attempts to make sense of these (Larkin, Watts, & Clifton, 2006).

IPA was opted for over other qualitative methodologies mainly as those who hear voices that no-one else can hear identify as a homogenous group, with limited literature from a first person perspective. Being able to focus wholly on giving a voice to these experiences was a distinct attraction of IPA. Furthermore, this stance allows for elements of reflexivity. The researcher is not taken as a blank slate, rather as someone with a personal and influential relationship with the participant accounts. It allows for tentative interpretations to be drawn, where it is acknowledged that they are subjective and therefore adopt the ontological stance of being a critical realist with the data (Larkin et al, 2006). The stance of critical realism acknowledges that there is a ‘reality’, yet counter-offers that the sense we as humans make of this ‘reality’ is pertinent.

As noted above, though DA was discounted for its methodological and ideological appropriateness, its links and references to social constructionism were something that I kept in mind. I cannot discount, therefore, its influence on my epistemological stance.

Social constructionism is, in essence, a theory that explores how mutually constructed understandings of the world have developed, where they are the basis of collective assumptions about reality (Burr, 2015). Aligning with a social constructionist stance also means aligning with the view that an individual’s lived experience is preferred over expert knowledge (Burr, 2015). This was attractive to me and felt like it fit with my views not only for how to conduct the present research but also in how I view the world. A social constructionist stance was how I was already viewing voice hearing; that it need not be pathologised and can be understood as a meaningful human experience. There is an interest within this stance for respecting the experiences of an individual as well as how these accounts are approached and respected within a system (Kim, 2001).
In all, though an IPA methodology was formally followed, as well as consideration for the hermeneutic stance, social constructionism also informed the development and conduction of this research. It could be argued that my own beliefs in social constructionism are one of the acknowledgements of reflexivity accounted for within an IPA framework.

References


Appendix O: Reflective statement

Deciding on my thesis topic

I remember the research fair so well. I was filled with enthusiasm and excitement as I listened to all my potential thesis supervisors talking about their areas of interest and the potential research projects that I could undertake. Beginning the doctorate, I hadn’t considered my thesis topic. A 3 year research project and I had no idea what I wanted it to be on. One area that struck me at the fair however was voice hearing. I knew nothing about it. I had never encountered it in my lifetime. I needed to know more. And it was as simple as that. After approaching what would become my thesis supervisors and banding around a few ideas I decided that I’d found my interest in voice hearing, now I needed to decide what I wanted to do with it.

Being raised in the Catholic Church, I had experienced what I fondly refer to as ‘Catholic guilt’ – when I do something that ‘isn’t very Catholic’, I know I shouldn’t, but do it anyway. For me this is something incredibly mild. I can laugh it off and make such fond references to it. But I began to wonder what it would be like for individuals who are strongly religious (or at least more so than me) to experience or do things that weren’t in line with their faith or spirituality, and then how they manage this conflict. And there we had a research project!

Journey with my empirical research

Once I’d reached that revelation the project seemed to move itself along quite organically; I navigated through each research proposal with relative ease, and became well-versed in talking all things voice hearing and spirituality. Then it came to making it ‘real’. Applying for ethical approval. Obstacle number 1. Originally I was interested in hearing people’s experiences both if they’d been in mental health services and where they hadn’t, so I took on the mammoth task of applying for both University and NHS ethics. Off I went to the NHS ethics board, which was a daunting enough task. Sitting in a grand room, unfamiliar environment, 20 other people there that have read through my proposal, all eyes on me and all scrutiny on my research. I felt I navigated this experience fairly well; I was able to answer all their questions, never felt like I was just ‘winging it’, and my supervisor told me I came across as professional. Then came the
response. I would be granted approval if I only recruit participants from mental health services. They ‘could not guarantee safety’ if I recruited from the community. This really struck with me. Why was my safety compromised by recruiting in the community? Surely it can’t be because of the individuals I’d be interviewing and was just a general concern for my safety? Surely the stigma against those that hear voices being ‘dangerous’ wasn’t that strong? Surely not. My ethics obstacles did not finish there. 6 months after applying for ethical approval, 5 months after appearing in front of the board, I finally received ethical approval. 6 long months of losing confidence and motivation in my research. 6 long months of watching others not only get their approval but begin recruitment.

It’s fair to say that I learnt a lot from my encounter with IRAS. The main thing being that a lot of this process is out of your hands, but it’s what you do with it and how you cope with it that counts.

After being given the ethical go ahead a big wave of relief washed over me, and I rode that wave. I got straight onto my field supervisor to kick off recruitment – I was armed with information and consent forms, and a can-do attitude. Obstacle number 2. Whenever you ask trainees in the year above about their theses and what we can do to make the process and manageable as possible, it’s always in the recruitment stages. “Make good links with teams”, “keep pestering!” were the most common pieces of advice I was given; both of which I followed too. On reflection, however, I understand that right before Christmas is a difficult time to start recruitment; everyone is busier and some have already mentally started preparing Christmas dinners so any information that wasn’t essential might just not make the cut. Some staff were incredibly eager to be involved in the research, though their identified participants either did not consent or were not at a ‘clinician established level of stability’ (to directly quote my inclusion criteria!). Others had too many queries about spirituality. “What is it?” I was often asked. “Anything, it’s a very subjective and individual construct. Some say this …” I would answer. Eventually, of course, people did agree to participate in my research and I am eternally grateful to these individuals, as well as the staff that helped in their recruitment. So, though I didn’t quite hit 6 participants, obstacle number 2 was overcome by April 2017. 2 months left to write up.
Obstacle number 3. The write up. Nobody really talks about the write up of your thesis. The logistics of it are discussed, but not the emotional turmoil that it will bring. I’m not sure if it’s because it’s the most recent stage I’ve had to navigate, or because it truly is quite difficult, but I really think it deserves some warning. I had never anticipated that the write up would be this challenging. It’s had the biggest impact on my social life, and self-care. It feels like mile 21 of a marathon. You’re well over half way, the beginning is a distant memory, you can almost taste the finish line, but it doesn’t come quickly enough. Sometimes I have felt like I was on top of everything, and ahead of the schedule I’d set myself, whereas other times I’ve felt like I’m so far behind it’s unachievable. There was a point though when I realised that I could never really be “on top” of my thesis, and I think that was a turning point for being able to navigate these final stages and retain a decorum of my sense of self.

Systematic Literature Review

It is notable that I have not once mentioned my SLR yet. I suspect this will not come as a surprise to my supervisors. This is something that I personally struggled with; not in the write up, the exhaustive trawl through the literature or the identification of a topic, but the whole concept. The ‘actual’ research (as it’s compartmentalised in my head) is my empirical research, the SLR was something I had to do, something that came with it. Writing this statement however, after finishing my portfolio thesis, I have a completely different mindset. I remember Chris, one of my supervisors, during one meeting tirelessly trying to motivate me to engage with my SLR. He spoke about how sometimes you needed to work with how effective an intervention or treatment was, which sometimes meant working with the numbers (something that I struggle to see as anything but objective and not person-centred) in order to make changes. He spoke about how if I wanted people to listen and begin to take note of and integrate someone’s spirituality or religion into their treatment plan, then I would first need to show that it works. It all felt a bit like common sense to me, but I hope that within my SLR I’ve been able to do the research justice.
Dissemination

So, now that my portfolio thesis is completed that leaves the question of where it is going. At interview, I offered all the participants who took part in the empirical study a summary of the results upon completion. This generated lots of excitement, not only among the participants but also with the care co-ordinators who had so gratefully given their time to identifying participants from this project. But that left me with the question of how I spread the message of this research out further. When selecting journals, one of my supervisors asked me a very obvious question yet it was one that I hadn’t considered: who would you like the audience of your research to be? That was how I came to decide on the journals for publishing.

I chose Clinical Psychology Review for my SLR because I wanted this to be read by clinicians. I wanted those that are Clinical Psychologists, trainees or with a keen interest in the area to take note that deciding how to work with an individual doesn’t stop at the model of therapy. It continues into how this can be best adapted to obtain the optimal results for the person you’re working with. It’s a review that encourages multi-modal working from a person-centred approach. This journal would therefore provide an appropriate platform for its message to be heard and upheld within services.

I then chose the Journal of Cross-Cultural Psychology for my empirical research. This journal felt most appropriate for my research as it is an interdisciplinary environment. It is a journal published in and read by psychologists, sociologists, and other individuals with a keen interest in the relationship between culture and behaviour. As a conclusion of my empirical research was for reflection and change at a systemic level, accessing an array of individuals and professionals at once felt appropriate to get its message heard. I felt this journal would provide a suitable platform to access as many interested individuals as possible.

The end

So there have certainly been some bumps in my thesis road. Some flew me higher than others, but I came back down from them all. Writing this reflective statement, and seeing in black and white a compilation of the obstacles I’ve had to overcome (not to
mention all the little stressors along the way) I am proud of myself. I’m proud of what I have achieved given what I have been up against. I’m proud that I’ve been able to pull myself out of my pits of despair and carry on (with a little help from my loved ones). I’m proud that as I hand in this piece of work, there are so many wonderful people in my life that may or may not understand what I do and may never do so, but are as equally proud of me.

My wonderful housemate and friend, Josie, has said something to me throughout that feels like the only right way to tie this up: we are all on a separate journey. And I wouldn’t do anything differently.