Narratives of voice hearing and mental health.

Submitted in partial fulfilment of the Doctorate in Clinical Psychology, Lancaster University.

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Abstract

This thesis focuses on the experience of voice hearing and effects on mental health and wellbeing. It is composed of two separate papers: a systematic literature review and an empirical paper.

Section one, the paper titled “Understanding indicators of clinical need and methods of reducing distress for children who hear voices: A Systematic Literature Review” aimed to establish the current research base which focuses specifically on the experience of voice hearing in children and the factors related to their current emotional health. The paper synthesised 13 quantitative studies. The majority of studies looked at different factors and two studies detailed interventions. The findings of the review suggest traumatic life events and cognitive appraisals may be important in the experience of distressing voice hearing. However no firm conclusions could be drawn due to small sample sizes and the variable quality of the included articles. There was some indication of CBT strategies being useful in mitigating distress however more evidence is needed. More research taking a consistent approach needs to be conducted in this area to establish the factors that may make some children who hear voices more vulnerable to experiencing distress and how they can be supported to manage their experiences.

Section two, the empirical paper titled, “‘I have finally realised I’m not crazy’: A narrative analysis of mental health and mediumship’”, aimed to explore how unusual experiences develop over time and how these experiences come to be seen as mediumistic. A data set of 14 interviews with mediums originating from a qualitative, pluralistic project was re-analysed using narrative analysis to consider how mediums view their experiences in relation to their own mental health. Findings show that mediums’ early experiences were often traumatic and builds on previous research by demonstrating that attempts to fit in with

social norms particularly around ‘healthy’ and ‘sane’ increases this trauma and distress. Participants sought out support from key figures, and validating responses were important for them to accept and establish their mediumistic identity.

Declaration

This thesis has been submitted in partial fulfilment of the Doctorate in Clinical Psychology at Lancaster University. The research reported is the author's own and has not been submitted for any other academic work.

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Contents

SECTION ONE: LITERATURE REVIEW

SECTION TWO: EMPIRICAL PAPER

SECTION THREE: CRITICAL APPRAISAL

SECTION FOUR: ETHICS FORMS

SECTION FIVE: APPENDICES

SECTION ONE

Literature Review

Understanding indicators of clinical need and factors relating to distress for children who hear voices: A Systematic Literature Review

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Abstract

Background: Previous research has focused on childhood experiences of voice hearing as predictors for future need; however there remains a cohort of children who experience persistent stress and distress related to voice hearing. This review considers research which focuses specifically on the experience of voice hearing in children and the factors related to their current emotional health.

Method: A systematic review following PRISMA guidance was conducted focusing on quantitative studies examining the experience of voice hearing in children aged 16 and under. PsychInfo, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Academic Search Ultimate, and The Allied and Complementary Medicine Database (AMED) were searched, with 13 studies meeting the inclusion criteria.

Results: The majority of studies looked at different factors. Findings suggest the importance of traumatic life events and cognitive appraisals in the experience of distressing voice hearing, however no firm conclusions could be drawn due to small sample sizes and the variable quality of the included articles. There was some indication of CBT strategies being useful in mitigating distress however more evidence is needed.

Conclusion: The findings highlight that few factors relating to the current wellbeing of children have been studied in relation to the experience of voice hearing. More research taking a consistent approach needs to be conducted in this area to establish the factors that may make some children more vulnerable to experiencing distress and how they can be supported to manage their experiences.

Keywords: voice hearing, children, review, quantitative, distress, wellbeing

Key Practitioner Message:

- Voice hearing is prevalent in children and young people and whilst this is transitory for the majority of individuals the experience of voice hearing can be distressing
- The persistence of voice hearing beyond childhood, as well as associated distress has been linked to poorer outcomes for adults
- This review focuses on factors relating to the current experience of voice hearing for children age <16 to try and determine what factors may be related to distress for these individuals and how they might be supported to cope
- More research needs to be conducted to establish which factors are related to distress for children who hear voices. There is some preliminary evidence that CBT skills and psychoeducation may be of benefit
- Unusual beliefs and negative appraisal styles may be related to increased distress, considering these when working with children who hear voices may be important

The experience of ‘voice hearing’, also referred to as auditory verbal hallucinations (AVH) within medical diagnostic terminology, is a complex set of phenomena characterised by the perception of sounds and voices not available to other people and without actual auditory stimulation (Moseley, Fernyhough, & Ellison, 2013). As noted in a recent review by Maijer et al (2019) one of the difficulties with drawing conclusions from research into ‘hallucinations’ (unusual sensory experiences not perceptible to others) is the wide range of phenomena that can fit into this category and a lack of a specific consensus on how to define these experiences. In order to aid comparisons across studies I have used the term ‘voice hearing’ throughout this review to describe the phenomenon of hearing voices which other people cannot and where these sounds are considered to originate from an entity separate to the individual hearing them. This is in contrast to hearing the ‘inner voice’ which while can also be considered a voice not accessible to others, is recognised as originating from the individual who hears it.

A further term used within this review concerns the experience of unusual beliefs or ‘delusions’, which are also considered one of the ‘positive’ symptoms of psychosis within medical frameworks. These are beliefs that are atypical of an individual’s background, culture and/or social history and are firmly sustained even in the face of incontrovertible proof or evidence (Chaudhury & Kiran, 2009). These are referred to as unusual beliefs throughout this review, except when it is needed to use the wording used by original authors of the included studies.

Although traditionally seen as a sign of mental ill health, in particular as evidence of psychosis, recent research suggests that voice hearing lies on a continuum as part of typical development (de Leede-Smith & Barkus, 2013; Maijer et al, 2019). Reports suggest that voice hearing is prevalent in the general population and recently research has started to make the distinction between those with a need for care and those without (Bevan, Read &

Cartwright, 2011). A review comparing voice hearers with and without a need for care (Johns et al, 2014) found those without a need for care experience more pleasant or neutral voices, are less likely to experience distress as a result of voice hearing, and typically report an earlier age of onset of around 12 years of age compared to around 21 years of age.

A meta-analysis conducted by van Os, Linscott, Myin-Germeys, Delespaul & Krabbendam (2009) found rates of childhood voice hearing to be between 5 and 16% and occurring mostly in late childhood to early adolescence. Furthermore, prevalence studies have found that childhood voice hearing is noted in conjunction with various clinical diagnoses including anxiety, depression, migraines and conduct disorder (de Leede-Smith & Barkus, 2013; Maijer, Palmen & Sommer, 2017). However, research demonstrates that the majority of children who report hearing voices in childhood do not continue to experience this in adulthood (Bartels-Velthuis, van de Willige, Jenner, van Os, & Wiersma, 2011).

Research looking at children and young people’s experience of voice hearing has tended to focus on long-term outcomes such as future mental health needs, as well as, the continued experience of voice hearing, or other psychotic like symptoms (de Leede-Smith & Barkus, 2013). Furthermore, research that has tended to consider voice hearing as an indicator of future mental health need often restricts inclusion criteria to diagnostic categories where voice hearing is the main or only ‘symptom’ such as schizophrenia or psychosis. Other diagnostic categories which include voice hearing within their definitions, for example bipolar and dissociative ‘illness’ are not included; consequently, there are potentially missed experiences and indicators of need (Johns et al, 2014).

A review by de Leede-Smith & Barkus (2013), proposed that the persistence of voice hearing beyond adolescence, rather than the incidence of voice hearing in childhood, may be predictive of a more severe underlying psychopathology. They considered the presence of childhood imaginary friends, often seen in young children and disappearing in adolescence (Jardri et al, 2014), as an indicator that voice hearing and other experiences which could be considered similar to hallucinations are not disadvantageous to children. The link between imaginary companions, inner voices and voice hearing is discussed in more detail in Fernyhough, Watson, Bernini, Moseley & Alderson-Day (2019). Furthermore, they also noted the development of unusual beliefs and distress as being predictive of individuals' future clinical need (de Leede-Smith & Barkus, 2013). As such individuals who have been diagnosed with a 'psychotic illness', tend to experience both unusual perceptions and beliefs and this association has also been seen in non-clinical populations (Escher, Romme, Buiks, Delespaul, & Van Os, 2002). This association supports theories that some unusual beliefs are secondary to anomalous experiences and arise as an attempt to explain these perceptual experiences implicating the role of cognitive processes in the attribution of these experiences to external forces (Escher et al., 2002).

More recent research has shown that adolescents experience of voice hearing is often mixed with individuals reporting both positive and negative aspects of their experiences. Parry & Varese (2020) found that voices had an important social function and the relationship between individuals and their voices was important in determining distress associated with voices. They highlighted the importance of understanding the form and function of voices for each individual and how sociocultural factor may influence the interpretation of these experiences.

Reviews and studies which have considered the predictive factors of distress for people who hear voices have to date typically focused on adult populations (see: de Leede-Smith & Barkus, 2013; Johns et al, 2014). Studies which consider children who hear voices tend to be longitudinal with the aim of establishing the course of 'illness' development or focused on neurodevelopmental or biological structures to explore illness pathways (Jardri et al, 2014). In addition, numerous studies focus on wider 'psychotic like' experiences such as 'subclinical schizophrenia' or hallucinations in general rather than voice hearing alone (Pilton, Varese, Berry, & Bucci, 2015). However, it has been increasingly recognised that it is more productive to research homogenous experiences rather than heterogeneous categories such as 'schizophrenia' which have poor reliability and validity (Bevan, Read & Cartwright, 2011).

Although longitudinal studies which consider the experience of voice hearing across the lifespan are useful for considering the continuum of risk of developing a need for care, it is also important to recognise that the experience of voice hearing can itself be distressing (Maijer, Palmen, & Sommer, 2017). Qualitative studies looking at non-clinical adult voice hearers suggest that their experiences in early childhood were often distressing and confusing and whilst these individuals did not go on to develop a clinical need as adults, they may have benefited from input to manage their experiences and distress in childhood. A key finding from qualitative research into the experience of voice hearing among non-clinical adult voice hearers has been the importance of a normalising validating family environment highlighting the importance of feeling safe when experiencing voice hearing as a child (Osborne & Bacon, 2015; Taylor & Murray, 2012; Roxburgh & Roe, 2014; Wilde et al, 2019). In addition, a recent study into adolescents' experience of voice hearing conducted by Parry, Loren & Varese (2020) found that the reactions of others as well as internalised stigma relating to the experience of voice hearing could influence voice related distress. This further highlights the importance of social and relational aspects in the experience of voice hearing.

Furthermore, studies have shown that it is at times of stress that these experiences are most likely to occur (Jardri et al, 2014). The link between trauma and hallucinations, particularly childhood sexual abuse and psychotic like symptoms, is well established (Varese et al, 2012). There therefore appears to be a group of children and young people who experience persistent stressful and distressing experiences, including the experience of voice hearing itself, who could benefit from clinical input prior to meeting the diagnostic requirements of psychosis. Developing a greater understanding of the factors which might affect the levels of distress experienced by children and the ways in which they might be supported to cope with the experience of voice hearing is important for both developing interventions to reduce distress for children who experience voices, and for the potential impact of reducing future need.

Method

Aim

The aim of this paper is to systematically review quantitative research which examines factors relating to the current experience of voice hearing amongst children aged ≤16 years, and to consider factors which may be related to their current emotional health and wellbeing.

Design

A systematic review following the checklist and guidance of Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA; Moher, Liberati, Tetzlaff, Altman & The PRISMA Group, 2009) was selected as the most relevant methodology to review current research. A systematic review uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review. Although the PRISMA statement was developed to focus on reporting systematic reviews of random control trials it can be applied to other types of research. Using a systematic approach ensures all relevant research is included in the review through the use of clear and identified inclusion criteria such that it can be replicated easily to ensure reliability.

Inclusion criteria

Articles included in the literature review had to meet the following criteria:

- Published in English, to allow the researcher to review the research.
- Published in a peer reviewed journal to maintain scientific rigour.
- Utilise a quantitative methodology
- Have at least one participant group age ≤16 with separate reported results. This age was chosen as the cut off point for children and adolescents as it reflects the age at which individuals typically move from childhood to adult services in the UK
- Consider the distinct experience of voice hearing and report results as such, i.e. not as part of "psychotic like" experiences. To meet this criterion included studies considered voice hearing as a distinct variable which was measured separately to other forms of unusual perceptions or beliefs.

Literature search

The following databases were searched: PsychInfo, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Academic Search Ultimate, and The Allied and Complementary Medicine Database (AMED). These were considered the most relevant databases to ensure a thorough literature search on this topic. The specialist librarian for the Doctorate in Clinical Psychology programme provided assistance with identifying as many relevant databases as possible during an optional seminar. No date limits were imposed on the search in order to retrieve as many relevant articles as possible. The search was conducted on 21/08/2020.

The search terms used covered two main areas of focus: 1) voice hearing and 2) children. In each database relevant subject headings and thesaurus terms were searched for each area of focus and combined with free text search. For example, in Psych Info the Index Term of "Auditory Hallucinations" was combined with free text searches of: "auditory verbal hallucination*", "AVH", "hearing voices", "voice hearing" using the Boolean term OR in order to cover the first area of voice hearing. These terms were selected to reflect this review's focus on the specific experience of voice hearing rather than wider categories such as 'hallucinations' which may include other sensory perceptions, or similar phenomenon such as imaginary companions. The second area of children was covered by searching age categories (denoted using ZG in Psych Info): (ZG "adolescence (13-17 yrs)") or (ZG "childhood (birth-12 yrs)") or (ZG "infancy (2-23 mo)") or (ZG "neonatal (birth-1 mo)") or (ZG "preschool age (2-5 yrs)") or (ZG "school age (6-12 yrs)") as well as free text searches of "young person" or "child*" combined with Boolean term OR. These two areas were then combined with the Boolean Term AND to search for articles which included both areas of focus (See Appendix for all search terms for all databases).

Further searches were made by reviewing the articles which met the inclusion criteria for additional reference citations that database searches may not have yielded.

Quality Appraisal

One researcher conducted this systematic review. Clear inclusion and exclusion criteria were established prior to conducting the search and a record of rejected studies, and the reason for their exclusion, was kept throughout the selection process in an attempt to ensure consistency and reduce bias.

The checklist for assessing the quality of quantitative studies, developed by the Alberta Heritage Foundation for Medical Research (AHFMR, 2004), was used to consider the quality of identified articles. This checklist was selected as it was developed specifically to provide a standard criterion to appraise the quality of research papers which adopt a wide variety of study methods within a systematic review. The checklist comprises 14 questions, scored on the degree to which each criterion is met ("yes" = 2, "partial" = 1, "no" = 0). Questions which are not applicable to a study are excluded from the calculation of the summary score which is calculated for each study. The summary score is calculated for each study as a total score of applicable criteria given as a percentage, this allows for a quality comparison for articles which may contain different methodologies. The AHFMR does not have a set threshold for low, moderate or high-quality studies, or a minimum quality threshold for study inclusion.

Data Synthesis

It was not possible to synthesise the data in a meta-analysis due to the heterogeneity of the articles included. Therefore, the synthesis focused on compiling a summary table outlining the main characteristics and findings of each article. Following this, trends and patterns were identified within the included articles. Key areas of investigation were grouped together to form headings, and the findings of any articles within these areas were summarised by grouping together those studies with similar/contrasting results.

Results

The search identified the following articles from each database: 267 from Academic Search Ultimate, 88 from CINAHL, 444 from Psych Info, and 529 from Medline Complete for a total of 1328 articles. After removing duplicates 496 articles were then reviewed against the eligibility and exclusion criteria with 412 excluded based on title and abstract. Of the articles read in full, 13 met the inclusion criteria. No additional articles were identified through the reference lists, or the forward citation search. Figure 1 provides a flow chart outlining the process of the search.

(Figure 1: Flow chart)

Characteristics of included studies

Eight of the studies included were based in the Netherlands (Bartels-Velthuis, Jenner, van de Willige, van Os & Wiersma, 2010; Bartels-Velthuis, van de Willige, Jenner, van Os, & Wiersma, 2011; Bartels-Velthuis, van de Willige, Jenner, Wiersma, & van Os, 2012; Bartels-Velthuis, Blijd, & van Os, 2011; Steenhuis, Bartels-Velthuis, Jenner, Aleman, Bruggeman, Nauta, & Pijnenborg, 2016; Brink, van Driel, el Bouhaddani, Wardenaar, van Domburgh, Schaefer, van Beilen, Bartels-Velthuis & Veling, 2020; De Loore, Drukker, Sabbe, van Os, & MyinGermeys; Maijer, Staring, Bartels-Velthuis, Palmen, & Sommer, 2020); two studies were based in Australia (Best & Mertin, 2007; Mertin & O’Brien, 2013); one in France (Askenazy, Lestideau, Meynadier, Dor, Myquel, & Lecrubier, 2007); one based in the U.K. (Vickers, 2002); and one in Japan (Fujita, Takahashi, Nishida, Okumura, Ando, Kawano, Toyohara, Sho, Minami, & Arai, 2015).

Seven studies used data taken from population-based surveys with five using the same case control sample of children aged 7 and 8 years attending primary school in the province of Groningen carried out during the school year 2002/2003 and later followed up in 2007/2008 (Bartels-Velthuis et al, 2010; Bartels-Velthuis et al, 2011; Bartels-Velthuis, Blijd, & van Os, 2011; Bartels-Velthuis et al, 2012; Steenhuis et al, 2016). However, the studies report separate results focusing on different variables and separate time points. Bartels-Velthuis et al (2010) reported the base line results when children were aged seven/eight; Bartels-Velthuis et al (2011) reported the first set of follow up data at five years when participants were 12/13 years old; Bartels-Velthuis, Blijd, & van Os (2011) also focused on the follow up sample, testing these participants on a Theory of Mind task; Bartels-Velthuis et al (2012) reported on the five year follow up data specifically relating to traumatic and stressful life events; Steenhuis et al, (2016) also considered the follow up sample and a measure of religiosity. These five studies were included in the results analysis but additional follow up results when participants were aged 18/19 years old were excluded as they did not consider the current emotional wellbeing of children aged 16 and under. Brink et al, (2020) also utilised data from a previously conducted study: the MasterMind study (el Bouhaddani et al, 2018) a large longitudinal study on adolescent mental health in the general population conducted in the provinces Noord-Holland, Zuid-Holland, and Noord- Brabant in the Netherlands collected from June 2013 until January 2015. Finally, De Loore et al (2011) utilise data from the Regional Youth Profiles compiled as part of standard health screenings conducted in South Limburg in 2004/2005 (Drukker, Wojciechowski, Feron, Mengelers, & Van Os, 2009).

One study used a case control design (Fujita et al, 2015) to investigate the odds of suicidal ideation or attempt when participants also hear voices. Two studies described the outcomes of different cases; Maijer et al (2020) reports on the clinical viability of a pilot intervention programme for those seeking help from mental health services in relation to voice hearing; and Vickers (2002) details the treatment protocol of a 12-year-old boy who had been struggling with auditory verbal hallucinations for a period of 14 months. Askenazy et al (2007) used a cross-sectional design to consider links between participants who heard voices and found these distressing and wider diagnostic criteria.

All of the studies included participants who were currently ‘hearing voices’; this was typically measured through self-report measures. The five articles reporting on the Bartles-Velthuis et al study and follow up data with the same sample (Bartels-Velthuis, et al., 2010; Bartels-Velthuis, et al., 2011; Bartels-Velthuis, et al., 2012; Bartels-Velthuis, Blijd, & van Os, 2011; Steenhuis, et al., 2016) used the Auditory Vocal Hallucination Rating Scale (AVHRS; Jenner, & Van de Willige, 2002) a 16-item structured interview to investigate the frequency, severity and quality of voices heard. One study used an adjusted version of this interview scale (Maijer, et al., 2020; see Maijer et al., 2017 for the measure). De Loore, et al.

(2011) used a self-report measure for the presence of voice hearing with the question ‘have you ever heard voices other people cannot hear?’ asked as part of the Regional Youth Profiles before gathering further information through clinical interviews. Other studies considered the presence of voice hearing using clinician referral or judgment based on clinical interview (Askenazy, et al., 2007; Best & Mertin, 2007; Fujita, et al., 2015; Mertin, & O’Brien, 2013; Vickers, 2002), the Dutch version of the prodromal questionnaire (PQ-16; de Jong et al, 2018) was also used by one study to measure presence and impact of voice hearing (Brink, et al., 2020).

The studies included considered several different areas relating to distress among participants who hear voices including demographic factors such as: age, gender, socio-economic status, and living in an urban vs rural area. Traumatic life events and / or post-traumatic stress were also considered in some studies, as were other mental health difficulties, family and developmental history, and cognitive factors such as unusual thinking. Distress was measured differently across the studies; five studies examined this directly through a measure of ‘AVH severity’ (Bartels-Velthuis, et al., 2010; Bartels-Velthuis, et al., 2011; Bartels-Velthuis, et al., 2012; Bartels-Velthuis, Blijd, & van Os, 2011; Steenhuis, et al., 2016). Six studies considered distress through the seeking of help for voice hearing and/or other clinical diagnoses (Askenazy, et al., 2007; Best & Mertin, 2007; Brink, et al., 2020; De Loore, et al., 2011; Fujita, et al., 2015; Mertin, & O’Brien, 2013) and two studies directly report on the reduction of distress following an intervention for voice hearing (Maijer, et al., 2020; Vickers, 2002).

All of the included studies used self-report measures to collect data using a mix of questionnaire and interview methods with participants and in some cases their parents. Further information was gathered using school attainment data in two studies (Bartels-Velthuis, et al., 2011; Bartels-Velthuis, Blijd, & van Os, 2011), medical records were used in three studies to gather information on early development (Bartels-Velthuis et al, 2010; Fujita et al, 2015; Vickers, 2002) and one study used a novel theory of mind task to examine cognitive abilities (Bartels-Velthuis, Blijd, & van Os, 2011).

(Table 1: Summary of study characteristics)

Quality of the studies

The quality of the studies included within this review ranged from 55% to 95% based on the AHFMR (2004), the total score for each article is given in Table 1 and full scores for each study are shown in Table 2. The AHFMR does not have a lower limit for study quality and given the limited number of studies available for inclusion in this review no studies were excluded on the basis of AHFMR quality score, although quality appraisals are considered when discussing study results.

From the quality appraisal some overall strengths and weaknesses were identified. All of the studies provided sufficient description of their aims and objectives and were able to justify their chosen methodology. Studies which scored the highest (over 90%; Bartels-Velthuis, et al., 2010; Bartels-Velthuis, et al., 2011; Bartels-Velthuis, Blijd, & van Os, 2011; Bartels-Velthuis, et al., 2012; De Loore, et al., 2011) were distinct in that they provided either partial or full evidence of accounting for variance, confounding variables and gave enough details in their results so that their analytical methods could be easily understood and replicated. Six studies performed below 75% (Askenazy et al, 2007; Best & Mertin, 2007; Fujita, et al., 2015; Maijer, et al., 2020; Mertin, & O'Brien, 2013; Vickers, 2002) indicating that they answered most questions as either partially or none, these studies performed the weakest and tended to only partially detail information relating to outcome measures, statistical tests conducted and had small sample sizes. Although two of the studies (Maijer, et al., 2020; Vickers, 2002) report on the outcome of interventions for people distressed by voice hearing, neither study design allowed for blind allocation to treatment or random allocation as they were case studies; one for an individual intervention (Vickers, 2002) and one a pilot study (Maijer et al, 2020) with no comparison data available.

The AHFMR (2004) does consider where a power analysis had been completed and allows interpretation that it has been completed with the particular score. The majority of the studies did not report all of the main results and outcomes of the study and reported none or only partial estimates of variance. Additionally, the majority of studies did not report enough information to allow for the researcher to calculate effect size.

(Table 2: Quality Assessment).

Factors relating to distress

13 studies were included in analysis and synthesised. These studies looked at a range of factors without much cross-over. As the factors considered and the quality of articles show a wide range, it was not possible to weight the results to reflect the quality appraisal and balance the comments throughout the discussion based on this weighting. Therefore, it is noted when the evidence is presented from either a high (>90%) or a low (<75%) quality study. The following factors were considered:

Demographic information

Studies that collected demographic information often did not consider this information as potential variables in their analyses. Only four studies reported the analysis of demographic data; in a medium quality study (82%; Brink et al, 2020) no evidence was found of a relationship between the discontinuation of distressing AVH and demographic details. De Loore et al., (high quality study >90; 2011) considered age, sex, socio-economic status and education level as a priori confounders, which when included in the statistical models, did not contribute a significant amount to either the persistence of AVH, general wellbeing or depressed mood in children who hear voices.

Three studies considered sex in relation to AVH; Bartels-Velthuis et al (2010, high quality study >90%) noted that girls who experienced AVH scored higher on intensity of suffering than boys who experienced AVH. However, in a later follow up study with the same sample, Bartels-Velthuis et al (2011, >90%) found that the severity of AVH was no longer associated with gender. Furthermore Askenazy et al. (2007) reported higher rates of AVH amongst boys than girls, although this did not consider the severity of AVH or the distress related to AVH and the results come from a lower quality study (75%).

Education level was found to be associated with voice hearing in some studies; Bartels-Velthuis, et al (2011) found that children with severe AVH had lower end-of-primary-school test scores than children with mild AVH and both groups had lower scores than children in the control group. In addition, Bartels-Velthuis et al (2010) reported that children attending urban schools were more likely than children attending rural schools to report voices associated with greater interference in thinking.

Findings relating to demographic factors showed mixed results in relation to gender and distress associated with voice hearing. There is some evidence that children who hear voices perform less well at school, although causation is unclear. This finding was greater in children attending urban schools supporting previous research relating to childhood adversity and voice hearing (Rosen et al, 2020).

Developmental factors

Two studies considered early development factors in relation to AVH related distress. Best & Mertin (2007) noted that interviews with parents of children who were seeking help with hearing voices did not reveal any significant developmental factors, or illnesses. Furthermore, whilst Best & Mertin (2007) scored lower on the AFHMR (<75%) these findings were supported by Bartels-Velthuis et al (2010, high quality study >90%) who found no associations with pre- and perinatal and early development variables for severity of AVH. Developmental factors were not considered by many of the studies included in this review and when they were examined these were found to have no association with voice related distress.

Religion

Steenhuis et al (2016, medium quality 77%) looked at the factor of religion in relation to severity of AVH. They found a significant association between religiosity groups (non-, moderately or strongly religious) and AVH, with a small to moderate effect size specifically, however when they considered the continuous measure of religiosity there was no significant association with the presence of AVH. Furthermore, there was no significant association between religiosity groups and severity of voices. Children with concurrent AVH and unusual beliefs or severe AVH were not more or less likely to be religious. This suggests a non-linear relationship between religiosity and AVH in children and it was found that moderately religious (as oppose to non-religious or strongly religious) participants were significantly more likely to report AVH.

Life Events

A wide range of life events were looked at across the included studies. Brink et al (2020, 82%) considered life events as protective factors and found: never having used cannabis, parents not being divorced in the past year, never having been scared by seeing a deceased body, less prosocial behaviour, and having repeated a school grade, to be predictive of discontinuation of distressing AVH. In contrast Bartels-Velthuis et al (2012, >90%) looked at the relationship between Traumatic Events (TE) and Stressful Events (SE) and found greater level of AVH severity was associated with stronger exposure to both TE and SE.

Two lower quality studies (Best & Mertin, 2007, <75%; Mertin & O'Brien, 2013, <75%) used an altered version of the Trauma Symptom Checklist for Children (TSCC-A; Briere, 1996) a self-report measure of posttraumatic distress and related symptomatology consisting of five clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress [PTS] and Dissociation). In a sample of children recruited from mental health services but without psychotic diagnoses, Best & Mertin (2007, <75%) found that of the 10 children who heard voices included in their study, eight scored highly on the TSCC-A, meeting clinical criteria. The most common subscale elevated into the clinical range was Depression and the Anxiety subscale was also prominent with six children obtaining elevated scores in the clinical range.

Mertin & O'Brien (2013, <75%) also used a sample of participants recruited from mental health services and found significantly more clinical scores on the TSCC-A subscales of Anxiety, Depression and Posttraumatic Stress, for participants who experienced AVH than matched controls who did not, with the PTS subscale showing the greatest difference between the two groups. This is similar to the findings noted by Askenazy et al, (2007, <75%) who found of 16 children who heard voices 10 reported a traumatic life-event: divorce (6/16); intra-familial violence (2/16) and death (2/16).

Therefore, there is some evidence to suggest that traumatic and stressful life events are related to distress associated with voice hearing similar to findings in adult studies (Varese et al, 2012).

Unusual beliefs

A high-quality study by De Loore et al (2011) considered the role of unusual thinking styles in the reporting of distressing AVH. They found that adolescents who experienced AVH were significantly more likely to report unusual beliefs than adolescents who did not. They reported that the effect sizes remained significant after controlling for potential confounders (depressed mood, demographic information). In addition, Bartels-Velthuis et al

(2012) found that the level of AVH severity also displayed strong associations with unusual beliefs.

One Study **(**Bartels-Velthuis, Blijd, & van Os, 2011, high quality study >90%) considered the links between Theory of Mind skills (ToM), unusual beliefs and AVH. They found a significant negative interaction between ToM score and AVH when looking at the outcome of unusual beliefs indicating higher likelihood of secondary unusual beliefs in AVH positive children who had lower ToM skills.

In contrast Brink et al (2020) found that the presence of cognitions which could be indicators of unusual thinking (having the feeling that others have it in for you, having anxiety when meeting new people, having lived through events exactly as if they happened before and having the feeling as if parts of the body have changed) to be predictive of the discontinuation of AVH. Although they caution that the confidence intervals for these results were wide.

Unusual beliefs were considered by several of the included studies and evidence was found to suggest that children who heard voices were more likely to also experience unusual beliefs. Findings relating to distress associated with voice hearing were more mixed perhaps as unusual beliefs could be used as a way to explain or manage voice hearing experiences as a protective measure as well as a potential source of more difficulties.

Mental health and Wellbeing

De Loore et al (2011) used four of the subscales of the Strengths and Difficulties Questionnaire, (SDQ; Goodman, 1997): emotional symptoms, conduct problems, hyperactivity–inattention, and peer problems; to measure what they called ‘general psychopathology’. They found that children who experienced AVH were significantly more likely to report ‘general psychopathology’ i.e. report greater difficulties in the strengths and difficulties questionnaire, than those who did not hear voices.

Best & Mertin (2007, low quality study <75%) reported that all of the children who reported AVH whilst seeking mental health support presented with symptoms of anxiety and/or depression, with two boys displaying additional aggressive and noncompliant behaviours.

Furthermore, De Loore et al, also looked at depressed mood and found adolescents who had experienced AVH were more likely to report experiencing depressed mood than those who did not. Brink et al (2020) considered the prosocial scale of the Strengths and Difficulties Questionnaire, (SDQ; Goodman, 1997). They found that adolescents with the lowest scores (scores 3–4/10) and the highest scores (scores 9–10/10) on the SDQ prosocial behaviour scale were part of the distressing AVH persistence group, while the adolescents with intermediate scores (scores 5–8/10) were part of the discontinuation group. This suggests a nonlinear relationship between prosocial behaviour and presence of distressing AVH, however, it could be argued that both low and high prosocial behaviour indicate wider problems with social interactions.

Bartels-Velthuis, et al (2011) found that children with severe AVH distress (but not children with mild AVH), compared with the children with no reported AVH, were more likely to show problem behaviour. Children with severe AVH distress were also more likely to score in the clinical range of psychopathology on the Child Behaviour Checklist scoring higher on ‘internalizing’ problems, ‘somatic complaints’, ‘anxious/depressed’, ‘social problems’ and ‘thought problems’. Although, a multinomial logistic regression showed that ‘somatic complaints’ appeared to be the only factor contributing significantly to AVH related distress severity.

Fujita et al (2015) looked at the link between suicidality and AVH. The main finding of this study was that among children referred to hospital settings with suicidal ideation, the presence of AVH was significantly associated with increased odds for suicide attempts, regardless of depression.

Multiple studies included in this review found that children who experience voice hearing also score higher on general measures of low mood and anxiety as well as social problems, demonstrating that voice hearing can be a distressing experience for some children.

Persistence of AVH symptoms

Brink et al (2020) found that the majority of participants who reported distressing AVH no longer reported this after one year. Bartels-Velthuis, et al (2011) found that children who still heard voices after 5 years, compared with children who no longer heard voices, had initially reported more severe AVH. This was also found by Askenazy et al (2007) who reported that the group with persistent AVH was characterized by the severity of hallucinations. In addition, Bartels-Velthuis, et al (2012) found that the proportion of children with severe AVH at follow-up was higher in the incident group (new AVH) than in the persistent group (ongoing AVH). These findings suggest that although voice hearing can be temporary for some children, when this persists it is more likely to be distressing for children, with older children more likely to report distress related to voice hearing.

Intervention aimed to reduce distress

Two studies describe interventions which aimed to reduce distress for participants who experienced AVH. In a low-quality study Vickers (2002, 55%) described a case study of the treatment for distressing AVH for a boy named ‘Daniel’. The treatment detailed within the article included family sessions of psychoeducation and normalising the voice hearing experience, followed by individual cognitive behaviour therapy (CBT) for symptoms of depression and skills building with Daniel and finally a pharmacological intervention. They noted that while normalisation of symptoms provided some relief for the family it did not improve mood or functioning for Daniel, the boy who was being treated. However, the CBT intervention aimed at improving Daniel’s problem-solving skills and distraction from the AVH improved his functioning and reduced the distress associated with hallucinations, although it did not reduce the frequency of them. It is important to note that while the article provides a strong rationale for the treatment it details and the results of this treatment, it does not provide any statistical tests or analysis. There is no report of any standardised measures, with school attendance and the presence (or lack) of ‘psychiatric symptoms’ the only outcomes provided.

In contrast, the intervention described by Maijer et al (2020, 75%), the stronger than your voices (STYV) pilot intervention study, assessed the impact of AVH pre and post intervention. Eight children and six therapists participated in the pilot study which consisted of CBT based intervention. They found an almost 40% decrease of total AVH impact after STYV therapy with a reported Cohen’s d within-group effect size of 1.28. However due to the small sample size, the estimate of the effect of the treatment is unreliable and no p-values were reported.

The common intervention strategy across both studies was the use of problem-solving skills and CBT based distress management techniques alongside psychoeducation and a focus on reducing negative beliefs and appraisals about the experience of voice hearing. While there is not enough strong evidence to make firm claims about either intervention the common elements indicate that reducing stigma and developing tools to help children manage their experiences are beneficial in reducing distress associated with voice hearing.

Discussion

This review aimed to synthesise research which examines factors relating to the current experience of voice hearing amongst children and to consider factors which may be related to their current emotional health and wellbeing. Overall, there was little evidence to form any strong conclusions as to the contribution of sociodemographic, early developmental, mental health, life experiences or cognitive abilities on children's experience of voice hearing. While some results can be seen as consistent with previous research into the prevalence and persistence of voice hearing in adult populations (de Leede-Smith & Barkus, 2013), specific conclusions into the relationship between these factors and the effect of experiencing voice hearing on current emotional health cannot be made. The findings were often inconsistent, which suggests it is likely a complex interaction of several factors which may make some children more vulnerable to experiencing distress associated with hearing voices.

Age was not found to be a significant contributor to depressed mood or general indicators of poor wellbeing for people experiencing AVH when entered into a statistical model (De Loore et al, 2011). However, Bartels-Velthuis, et al (2012) noted that AVH severity scores were higher for children reporting new AVH at follow up than those with persistent AVH. This suggests that those who reported first instance of AVH at a later age (12/13 years) found this more distressing than those who first reported AVH at a younger age (7/8 years). These findings reflect the general trend in the literature with an early age of onset being linked to 'non-clinical' voice hearing and lower distress. However, this comparison is usually made across a wider timeframe, for example when comparing childhood onset below the age of 12 and adult onset after 21 (Johns et al., 2014).

Socioeconomic status was not measured directly or reported on in any of the included studies, however education level was considered as a measure of socioeconomic status in the De Loore et al (2011) study; no significant effect was found, however. These findings are consistent with other research into AVH in child and adolescent samples with no significant differences noted amongst demographic variables for children who hear voices with and without a need for care (Maijer, Steenhuis, Lotgering, Palmen, Sommer & Bartels-Velthuis, 2019). Previous research with adult samples, however, has shown some links between voice hearing and poverty as well as other indicators of childhood adversity (Rosen et al, 2020).

Biological factors such as pre- and peri-natal complications and delayed developmental milestones have been found to be associated with the development of psychosis (de Leede-Smith & Barkus, 2013). However, within this review only two studies looked at developmental factors and neither found any significant associations with current emotional wellbeing for children who hear voices (Best & Mertin, 2007; Bartels-Velthuis et al, 2010). This suggests either no link between distressing AVH and these biological factors or a more complex association which may be mediated by other factors.

The differences between the finding in the studies included in this review and previous research with regards to developmental factors may be due to the difference surrounding the exclusion criteria. Previous research which has found an association between developmental factors has considered those meeting the criteria for a clinical diagnosis of psychosis compared to the experience of voice hearing. It is increasingly recognised that heterogenous categories, such as psychosis, can have poor reliability and validity and it is more productive to consider homogenous categories such as voice hearing separately (Bevan, Read & Cartwright, 2011). As such the findings from studies including those with psychosis may not be fully comparable to those which focus on voice hearing without the presence of addition ‘psychotic like symptoms’ such as visual hallucinations.

The role of cognitive processes in the development and experience of voice hearing has generated a lot of research interest and studies of cognitive functions have found numerous correlations with voice hearing (Johns et al, 2014). One of these cognitive components is a negative appraisal of the tone of the voices which has been suggested to elicit unusual thinking and beliefs as individuals are unable to recognise the voice potentially being internal to them, instead attributing this to external forces (de Leede-Smith & Barkus, 2013). This is supported by the findings in this review. Bartels-Velthuis et al (2010) found children with more severe AVH scores were more likely to attribute voices to external factors. Additionally, Mertin, & O'Brien (2013) found the majority of children who were distressed by AVH reported threatening voices, indicating that more negative, threatening tone in voices is related to greater distress.

In contrast, the ability to mentalise and an absence of reasoning biases was shown to reduce the formation of threatening appraisals about hearing voices (Escher, et al 2002; Polanczyk et al, 2010). This suggests that children with greater Theory of Mind skills may be more protected from developing negative appraisals of voices and therefore be less likely to experience distress as a result of hearing voices. One of the included studies (Bartels-Velthuis, Blijd, & van Os, 2011) found that in a sample of children who hear voices those who scored lower on Theory of Mind skills were more likely to report unusual beliefs; supporting the idea that misattribution of voices or more negative appraisals can lead to further difficulties and greater associated distress.

Unusual beliefs and thinking styles were also considered in two other studies. Bartels-Velthuis et al (2012) found that unusual beliefs were strongly associated with severity of AVH and the presence of traumatic or stressful life events; however the combination of AVH and unusual beliefs were more strongly related with traumatic or stressful life events than AVH severity or unusual beliefs alone. Therefore, it is unclear from this study whether AVH severity or distress is directly related to unusual beliefs or whether these were related to the presence of traumatic or stressful life events. De Loore et al (2011) reported that persistence of AVH was related to presence of unusual beliefs with more persistent AVH related to greater odds of experiencing these. This supports the finding by Bartels-Velthuis, Blijd, & van Os (2011); that children who experience more severe AVH also report more unusual beliefs, and children who hear voices regardless of severity report higher rates of unusual beliefs than children who do not hear voices.

These findings support the idea of persistent or distressing AVH being related to secondary unusual beliefs (Johns et al, 2014). These findings are also consistent with wider research into the relationship between persecutory beliefs, depression, and hallucinations which show high levels of association between all three variables (Smith et al, 2006). Due to the small sample sizes used in the included studies it is not possible to draw strong conclusions about the association between voice hearing and either factor. Untangling anomalous experiences from other indicators of mental health problems is an often reported difficulty and can require extremely large sample sizes, typically those involving thousands of participants such as the Avon Longitudinal Study of Parents And Children studies (ALSPAC; Niarchou, Zammit, & Lewis, 2015).

In relation to potential protective cognitive factors, such as having a normalising explanation or frame of reference for voice hearing (Osborne & Bacon, 2015; Taylor & Murray, 2012; Roxburgh & Roe, 2014; Wilde et al, 2019); only one study considering religion was found within this review. In this study (Steenhuis et al, 2016), adolescents with concurrent AVH and unusual beliefs or severe AVH were not more or less likely to be religious however moderately religious participants were significantly more likely to have recently developed AVH than non- or strongly religious participants. This suggested that religiosity in children may be related to AVH; however, it may be a more complex non-linear relationship. For instance, those with strong religious beliefs may be able to use this as a coping strategy for managing AVH. Indeed, the majority of participants reported that they found religion to be positive and useful regardless of AVH severity or religiosity (Steenhuis et al, 2016). There is a range of literature which demonstrates the differences between cultures when considering the experience of voice hearing. While in western cultures hearing voices is typically seen as a negative many religions and cultures consider hearing voices to be spiritual in nature rather than a sign of mental ill health (Hunter & Luke, 2014). The findings of this review suggest that providing families and children with normalising and validating psychoeducation about their experiences was beneficial in reducing their distress. Further research considering the role of cultural and societal beliefs and stigma on the experience of distress in relation to voice hearing is needed within child samples.

In line with previous research children who hear voices reported a range of difficulties with mood, behaviour and social interactions (Askenazy et al, 2007; Bartels-Velthuis et al, 2010; Bartels-Velthuis et al, 2011; de Loore et al, 2007; Fujita et al, 2015; Mertin & O'Brien, 2013). However, none of these studies considered the direction of these relationships, making it unclear whether the difficulties with mood, social interaction and behaviour were due to the presence of AVH, or whether they contributed to the presence of AVH.

Depressive symptoms are common in people with psychotic experiences and AVH; it is thought that beliefs about the voices can lead to feelings of powerlessness particularly for those who feel overwhelmed by voices (Escher, Delespaul, Romme, Buiks, & van Os, 2003). Some of the findings within this review indicate that the relationship between factors associated with voice hearing distress may be more complex with interactions between factors as well as with voice hearing severity or distress. For example, the finding by Brink et al (2020) that individuals who scored in the intermediate scores on the prosocial scale were least likely to be part of the persistent distressing AVH suggests a nonlinear relationship between prosocial behaviour and presence of distressing AVH, however, it could be argued that both low and high prosocial behaviour indicate wider problems with social interactions.

Where traumatic life events were reported, these appeared positively associated with voice hearing and distress related to voice hearing (Bartels-Velthuis, et al, 2012; Best &

Mertin, 2007; Brink et al, 2020; Mertin & O’Brien, 2013; Vickers, 2002). This is in line with previous research demonstrating a strong link between traumatic life events and voice hearing in adult and retrospective studies (Daalman, Diederen, Derks, Van Lutterveld, Kahn & Sommer, 2012). However, it is important to note that the presence of traumatic and stressful life events was most often noted in studies which were descriptive. These studies did not consider comparison samples, or rates of traumatic events were not reported in the statistical results given (Best & Mertin, 2007; Vickers, 2002). Only one study in this review compared levels of severity of AVH and traumatic and stressful life events, Bartels-Velthuis et al (2012) and while they found an association with traumatic and stressful life events and AVH this was stronger for the combined consideration of AVH severity and unusual beliefs than either of these alone.

Two of the included studies give details of interventions for children who are experiencing distressing AVH. Both used a CBT based intervention and included sessions on psychoeducation about voice hearing, normalising this for participants and their families. These studies both provide a good rationale for their intervention and support the use of acceptance and normalisation of voice hearing which has been found to be helpful in adults who hear voices (see Thomas et al, 2014 for a review of interventions for voice hearing). Additionally these findings are in line with other research which has demonstrated the importance of social factors in the experience of voice hearing, with supportive environments described as mitigating voice hearing related distress (Osborne & Bacon, 2015; Taylor & Murray, 2012; Roxburgh & Roe, 2014; Wilde et al, 2019; Parry & Varese, 2020). Furthermore, the use of CBT based strategies such as distraction and skills-based problem solving appears to have reduced other symptoms such as depression and social difficulties for the participants. However, as these studies are both case descriptions (a case study and initial pilot respectively) they do not provide comparative groups or clear indication of generalizable clinical benefit. More research is needed to effectively evaluate these interventions for children distressed by voice hearing.

Strengths and limitations of included studies

This review showed some high-quality studies which utilised population surveys and information potentially allowing for large sample sizes, these studies reported their results in a clear manner, considered estimates of variance and effect size and clearly built on previous research. However, the majority of these studies shared some of the same authors and population data, based in the Netherlands which limits the generalisability of these findings to other populations. Furthermore, the low rates of voice hearing in these samples still results in smaller samples of children who hear voices when comparing between groups.

Furthermore, the majority of the research used case series or correlational evidence when considering the impact of different factors on AVH severity and distress with limited use of control groups. The focus of the research has also remained on the prevalence and persistence of AVH, although this review focused on results relating to children's current emotional wellbeing many of the included studies also looked at follow up and persistence of symptoms rather than current impact.

Limits of review

It is important to note that this review had some methodological issues. One of the main difficulties in conducting this review was the 'cut off' age for children and adolescents. The age 16 was chosen by the author due to services within the UK considering 16 to be the age at which individuals access adult services. However, only one of the included studies was based in the UK, the lowest quality study which detailed a single case study (Vickers, 2002).

Therefore, it may be that this age limit does not accurately reflect the rest of the literature around child and adolescent AVH.

Several studies which were excluded due to including participants up to the age of 19 or 21 may have been useful to include in this review as they focused more on distress and coping for individuals who hear voices. (Escher et al 2002; Escher et al 2003; Majier et al, 2017). On the other hand, these studies used a large age range (e.g. Escher et al, 2003, age range 8-19 years; Maijer et al, 2017 age range 6-18 years) which may not accurately reflect either end of the range – young children or young adults. It has been found that individuals who first hear voices before the age of 12 are less likely to have clinical need than those aged 21 or over (Johns et al, 2014). Therefore, studies which consider children under 12 and those over 18 within the same group may not be specific enough to accurately portray such differences when results are not reported separately.

Furthermore, many studies consider voice hearing to be part of ‘psychotic like’ experiences or consider voice hearing as part of the wider term hallucinations which prevented them from being included within this review. In particular studies which are based in the UK and include large sample sizes or interventions for children who hear voices tend to focus on the wider term psychotic like experiences (Niarchou, Zammit, & Lewis, 2015). Although we have argued that voice hearing should be better considered separately to wider psychotic like experiences, this has prevented more studies from being included within this review as separate results for AVH specific experiences were not reported.

Finally, this review was conducted by one reviewer (the author) and therefore is more prone to bias and human error. Logs of key decision and the steps taken were kept to try and minimise this bias however it is possible that some studies were missed.

Implications and future research

This review highlights that there is limited evidence into the current emotional wellbeing of children who hear voices and the factors which may lead to distress or clinical need. There is a need for more research to be conducted in this area to develop our understanding of how to identify and support children and young people who may experience distress as a result of AVH, as well as more research into potential interventions for these individuals. While there is a small amount of evidence for CBT based interventions and psychoeducation in the reduction of distress for children who hear voices, more rigorous research with larger samples and control variables is needed to establish how best to support these individuals. This research needs to take a more consistent approach to the populations included, considering whether there is a distinction between younger children and adolescents' experience; as well as the variables measured, and the definitions of psychological distress being considered. It would also be beneficial to establish further whether voice hearing can be considered as equivalent to the wider term 'psychotic like' or whether there are differences in functional outcomes or factors relating to distress.

With recent qualitative studies considering children and young people's experiences of voice hearing highlighting the importance of social and relational factors (Parry & Varese, 2020) future research which considers positive aspects of voice hearing as well as current emotional wellbeing and social support could be helpful in demonstrating factors relating to distress and in helping to normalise these experiences as part of a continuum of experience.

Conclusion

This review synthesised the quantitative literature which examines factors relating to the current experience of voice hearing amongst children and to consider factors which may be related to their current emotional health and wellbeing. The majority of articles included in this review used population samples taken from the Netherlands, however the numbers of children who hear voices within these samples were relatively small and the other included studies all had limited numbers, focusing on descriptive characteristics. The findings of this review focused on a range of different factors and the results were inconclusive and contradictory, where associations were found these were often complex and non-linear. The findings highlight that few factors relating to the current wellbeing of children have been studied in relation to the experience of AVH. Therefore, it is essential that more research taking a consistent approach is conducted in this area in order to establish the factors may make some children more vulnerable to experiencing distress as a result of AVH and how they can be supported to manage their experiences.

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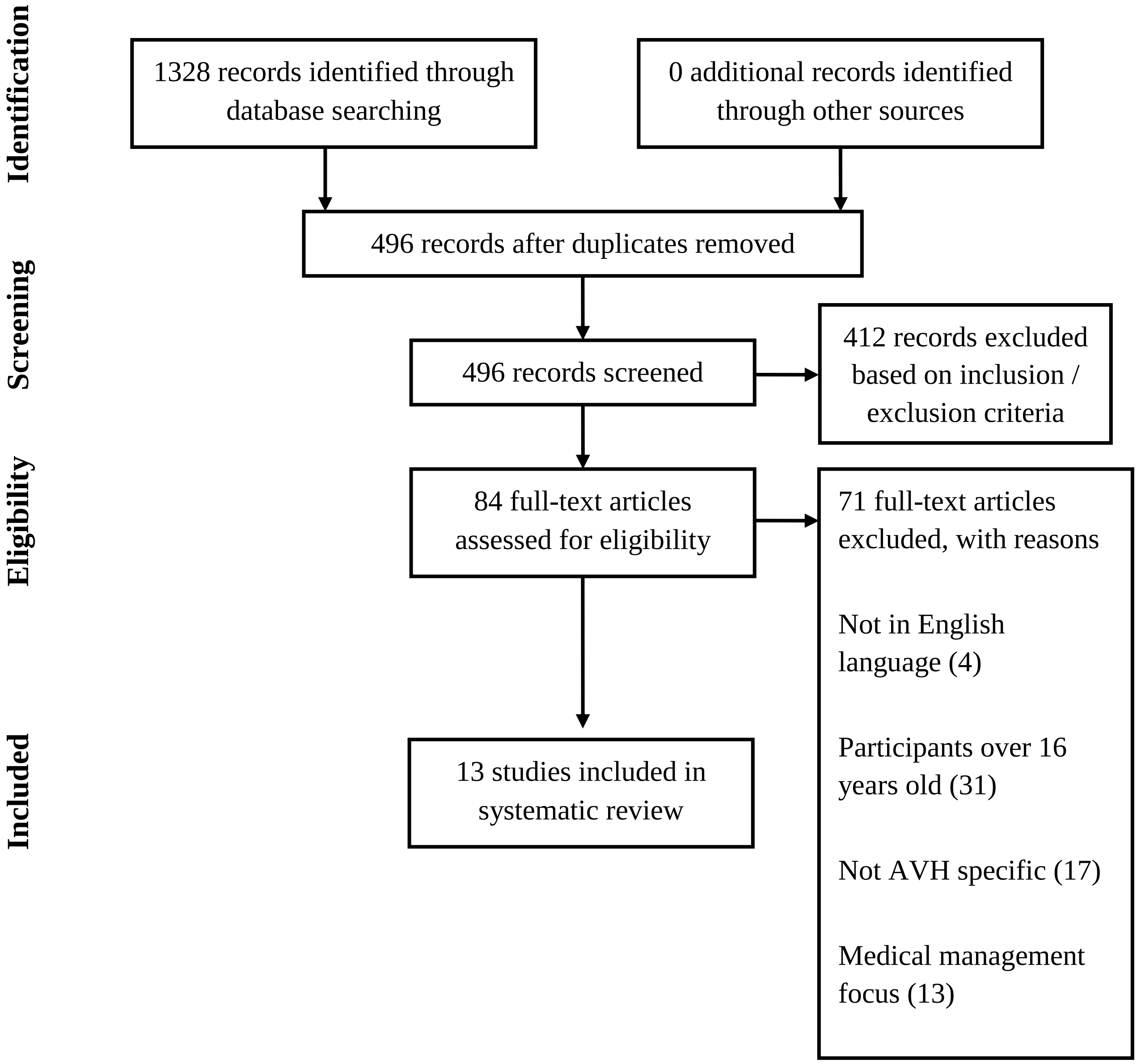

Figure 1. Overview of literature search and inclusion.

Table 1.

Key methodological features and findings from reviewed studies

Citation	Aim	Design/participants	Psychosocial variables measured	Findings
Askenazy, Lestideau, Meynadier, Dor, Myquel, & Lecrubier. (2007). France	To describe the phenomenology of auditory hallucinations in children, and to establish links with DSM IV diagnoses. To explore the development of the hallucinations over a 12-month period.	A descriptive cross-sectional study. A sample of consecutive outpatients aged 5- to 12-year-old recruited in a one-year period from a hospital setting. Ninety children were recruited. Sixteen reported auditory hallucinations, confirmed through clinical interviews.	Information about traumatic life events were obtained: death in the family; divorce; moving to a new house; miscarriage or abortion of the mother; sexual abuse, family violence. The K-SADS-PL generating DSM III-R and DSM IV diagnosis was performed. Current distress was considered through diagnosis of mental health conditions, and recruitment from hospital setting for children currently struggling with their mental health.	The mean age of onset of hallucinations was 6.5 years. In 10 cases (62.5%), a traumatic life-event was revealed. Diagnoses observed were: separation anxiety (8/16; 50%). Obsessive-compulsive disorders (7/16; 44%); conduct disorders (6/16; 37%); attention deficit hyperactivity disorder (5/16; 31%) and depressive disorders (5/16; 31%) were also common.

Bartels-Velthuis, Jenner, van de Willige, van Os & Wiersma. (2010). Netherlands.	To investigate prevalence, developmental risk factors and behavioural correlates of auditory vocal hallucinations in 7- and 8-year-olds.	A sample of 3870 children was collected through a nationwide survey of school children aged 7 or 8. 347 of these children screened AVH-positive. Age 8 and 7-year-olds (77% v. 68%). Boys and girls were equally represented. Auditory vocal hallucinations were assessed with the Auditory Vocal Hallucination Rating Scale (AVHRS) a 16-item structured interview	The Infant Health Service records provided data on pregnancy and the child’s condition immediately after birth. Data on early development were gathered from the Van Wiechen Developmental Test (VWDT). The child behaviour checklist (CBCL) measures social and physical functioning: social withdrawal, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, rule-breaking behaviour, aggressive behaviour and sexuality. Prescence and intensity of voices and associated distress were measured as part of AVHRS.	Girls scored higher on intensity of suffering and on anxiety. Children attending urban schools reported hearing two or more voices more frequently than those attending rural schools. In addition, they more often reported hearing voices speaking simultaneously and voices associated with greater interference in thinking. Attributing voices to an external source was associated with severity of AVH as was increased reporting of somatic complaints.

Bartels-Velthuis, van de Willige, Jenner, van Os, & Wiersma. (2011). Netherlands	To investigate the persistence and new incidence of auditory vocal hallucinations, as well as their clinical relevance in terms of problem behaviour, severity and associations with aetiological variables in a follow up sample of children who experienced auditory vocal hallucinations.	Longitudinal cross-sectional design. The same sample of 337 children as described above, now 12 and 13 years of age, 5 year follow up from initial baseline sample of 694. AVH measured by AVHRS.	Repeated the 16-item AVHRS structured interview. Use of substances (cannabis, synthetic drugs such as ecstasy, amphetamines, cocaine and heroin) was assessed by a self-report questionnaire. school attainment level was taken as a measure of general cognitive ability. The CBCL a self-report questionnaire for parents regarding their child's behaviour was repeated.	The majority (76%) of the children with auditory vocal hallucinations at age 7 or 8 years no longer heard voices at the age of 12 and 13 years. Persistence was associated with greater severity of auditory vocal hallucinations at baseline. New incidence of AVH was associated with more current problem behaviour and severity of AVH than remitted or persistent AVH.
Bartels-Velthuis, van de Willige, Jenner, Wiersma, & van Os. (2012). Netherlands.	Investigated associations between (severity of) auditory vocal hallucinations (AVH) and (i) social adversity [traumatic experiences (TE) and stressful events (SE)] and (ii) delusional ideation.	A total of 337 children who hear voices. Same sample as above, five year follow up. Article reports unique findings. At baseline and at follow-up, auditory hallucinations were assessed with the 16-item AVHRS.	At follow-up, delusional ideation was assessed with three items, TE were assessed at follow-up using an interview questionnaire. The questionnaire consists of six items: sexual approach/ abuse, Internet blackmailing/ threatening, undeserved punishment, being an eyewitness to: (i) serious accidents, (ii) robberies or (iii) threats. SE were assessed at follow-up by questionnaire.	Both TE and SE were associated with both incident and persistent AVH, as well as with greater AVH severity and delusional ideation at follow-up. In addition, the combination of AVH and delusions displayed a stronger association with TE and SE compared with either AVH or delusions alone.

Bartels-Velthuis, Blijd, & van Os. (2011). Netherlands.	To examine the social cognitive vulnerabilities mediating delusion formation in children presenting with hallucinatory experiences.	Taken from the longitudinal cross-sectional sample at 5 year follow up as described above. Total of 259 participants in the analysis who completed the Theory of Mind (ToM) test.	A new ToM task was developed for children aged 10–14 years, analogous to the ToM Storybooks for younger children. Presence of AH at follow-up and delusional experiences were assessed through interview questions. As a global measure of intelligence, secondary school level was assessed: 1 (lower ⁄ vocational) and 2 (higher ⁄ preacademic).	Auditory hallucinations at age 7⁄8 and⁄ or age 12 ⁄ 13 years were reported by 52% (n = 134), at least one definite delusion by 28% (n = 71) and 55% of the children (n = 135) attended secondary school at a higher level. Children who experienced AVH more likely to report delusions. Children who scored lower on ToM task also more likely to report delusions.
Best & Mertin. (2007). Australia	To examine correlates associated with auditory hallucinations in nonpsychotic children, including family histories, and the nature of the auditory hallucinations themselves, and to compare this population with studies using similar clinical populations of children. In addition, any links these children might have with imaginary companions was also investigated.	Sample consisted of 10 children (4 male, 6 female) aged between 8 and 14 years.1	The referring parent was interviewed using a structured interview format designed to assess current family structure, family history as well as the child's developmental history. The child was then interviewed about aspects of the auditory hallucinations including number of voices heard, the duration and frequency of the hallucinations, and the content of messages (if any). The child was administered the Trauma Symptom Checklist for Children – Alternate version (TSCC-A).	Found strong associations between presence of AVH and family dysfunction, specifically family break-up, as well as significant levels of anxiety and depression in the presenting children. In addition, half the children reported the presence of imaginary companions.

Brink, van Driel, el Bouhaddani, Wardenaar, van Domburgh, Schaefer, van Beilen, Bartels-Velthuis & Veling. (2020). Netherlands	Explorative study to investigate predictors of spontaneous discontinuation of distressing AVH in a school-based sample.	Taken from a sample of 1841 adolescents whose data was collected for the Master Mind study into adolescent mental health. The current study included 123 adolescents who reported at least mild distressing AVH at baseline who were then followed up one year later. Age ranged from 12-14 years old. Presence of distressing AVH was determined by a positive answer to the item “I have heard things other people can- not hear, like voices of people whispering or talking” on the Prodromal Questionnaire (PQ-16)	Longitudinal study using self-report questionnaires at baseline and follow up. Baseline: Life events, Peer status, Psychosocial problems (SDQ), Psychotic experiences (PQ-16), Self-esteem (RSE), Socio-demographic characteristics, Somatic symptoms (SAHA) Follow up: Discrimination, Life events, Locus of control (Mastery), Psychotic experiences (PQ-16), Religion, Substance abuse (SAHA), Trauma (DISC)	Outcome at 12-month follow-up was defined as spontaneous discontinuation of distressing AVH. Discontinuation of distressing AVH could not be predicted by socio-demographic characteristics, but was predicted by never having used cannabis, parents not being divorced in the past year, never having been scared by seeing a deceased body, less prosocial behaviour, having repeated a school grade, having the feeling that others have it in for you, having anxiety when meeting new people, having lived through events exactly as if they happened before and having the feeling as if parts of the body have changed

De Loore, Gunther, Drukker, Feron, Sabbe, Deboutte, van Os, & MyinGermeys. (2011). Netherlands	Aims to investigate, in a large sample of representative adolescents in the general population, to what degree hallucinations persist, and whether persistence of hallucinations increases the risk of developing secondary delusional ideation and affective dysregulation.	The present study used two waves of these Regional Profiles of Youth health (RPY), pertaining to 1912 adolescents living in Maastricht and surrounding areas (total population of 201,000) who were attending the second grade of secondary school at T0 (age 13/14 years) and who were seen again approximately 2 years later at T1 whilst attending the fourth grade (age 15/16 years).	Auditory hallucinations measured at T0 and T1. Delusional ideation measured at T0 and at T1 General psychopathology was measured at T0 and T1 using the Strengths and Difficulties Questionnaire (SDQ) also measured demographics including age, sex, educational level at T1	Five percent of adolescents reported hallucinations at T0 and 27% of these hallucinations were still present 2 years later. Hallucinations at T0 were associated with increased levels of depressed mood and general psychopathology at T1, and the degree of persistence of hallucinations was associated with a progressively greater risk for T1 delusional ideation as well as increased levels of follow-up depressed mood and general psychopathology.
Fujita, Takahashi, Nishida, Okumura, Ando, Kawano, Toyohara, Sho, Minami, & Arai. (2015). Japan.	To investigate the association between AVHs and suicide attempts among patients with suicidal ideation in clinical settings.	The sample consisted of first-visit psychiatric referrals aged 10–15 years, using a cross sectional study design. 608 participants were finally analysed.	Self-reported questionnaire included items regarding the following: 1) suicidal ideation and suicide attempts; 2) AVHs; and 3) depression. Also collected data on demographic characteristics from medical records.	Among 188 patients with suicidal ideation, the presence of AVHs was associated with increased odds of suicide attempts (OR 3.4, 95% CI 1.7–6.9; p b 0.05); however, depression was not associated with a significant change of odds. AVH was associated with increased odds of suicidal ideation and depression.

Maijer, Staring, Bartels-Velthuis, Palmen, & Sommer. (2020). Netherlands	Investigated feasibility and clinical outcomes of the “Stronger Than Your Voices” (STYV) therapy.	Six participants (10–16 years old), all suffering from comorbid psychopathology. Participants were derived from children and adolescents seeking help for AVH at the UMC Utrecht outpatient clinic.	Demographics, clinical, and AVH characteristics assessed at baseline using an adjusted version (Maijer et al., 2017) of the Auditory Vocal Hallucination Rating Scale (AVHRS) (Bartels-Velthuis, van de Willige, Jenner, & Wiersma, 2012). Clinical outcome measured using the 16 questions from the STYV Strong Measurement Form.	AVH total impact decreased 40% suggesting clinically meaningful change. Therapists were positive about STYV therapy and manual.
Mertin, & O’Brien. (2013). Australia	To assess the association between high levels of trauma symptomatology, anxiety and depression, and the presence of hallucinations against matched controls.	The index group consisted of 20 participants (9 male, 11 female), aged between 8 and 15 years, who were drawn from two community-based child and family centers in Adelaide, Australia, who experienced AVH. The control group consisted of 19 participants (10 male, 9 female), drawn from the same community-based child and family centres who reported no AVH, and broadly matched for age and gender.	Current family structure and family history (including psychiatric illness, domestic violence, and drug/alcohol use in family members), as well as the child’s developmental history assessed via parental interview. Children interviewed on features of their hallucinations, including the number of voices heard, and the duration and frequency of the voices, and were also administered the Trauma Symptom Checklist for Children – Alternate Version	Results indicated that hallucinating children had significantly higher mean anxiety, depression and, in particular, re-experiencing scores than did the children in the control group. The majority of children experiencing AVH were distressed by voices and heard threatening voices.

Steenhuis, Bartels-Velthuis, Jenner, Aleman, Bruggeman, Nauta, & Pijnenborg. (2016). Netherlands.	Examined the associations between auditory vocal hallucinations (AVH) and delusions and religiosity in young adolescents	337 children from a population-based case-control study with and without AVH, were assessed after five years at age 12 and 13, on the presence and appraisal of AVH, delusions and religiosity. Taken from the same sample as Bartles-Velthuis et al, as above.	AVH status (persistent, remittent, incident or control) was examined in relationship to religiosity. Delusional ideation was assessed with three items enquiring about ‘mind reading’, ‘paranoid ideas’ and ‘receiving media messages’, originating from the Diagnostic Interview Schedule for Children positive and useful voices were assessed with two items from the Positive and Useful Voices Inquiry. Religiosity was assessed with the five questions from the Dutch Spirituality and Religiosity Questionnaire	Results demonstrated a non-linear association between AVH and religiosity. Moderately religious adolescents were more likely to report AVH than non-religious adolescents. Prospectively, moderately religious adolescents were more likely to have recently developed AVH than non-religious adolescents and strongly religious adolescents. Of the adolescents reporting voices in this sample (16.3%), more than half reported positive voices. Religious beliefs were often described as supportive, useful or neutral (82%), regardless of the level of religiosity, for both adolescents with and without AVH. Co-occurrence of AVH and delusions, and severity of AVH were not related to religiosity.
Vickers, B. (2002). UK.	Description of a case study of a 12-year-old boy with a 14-month history of second-person auditory hallucinations associated with a diagnosis of severe depression is presented.	12-year-old boy with a 14-month history of second-person auditory hallucinations associated with a diagnosis of severe depression.	Considered demographics: age, gender, as well as family history and symptomatology, birth and development, traumatic incidents and treatment course	Successful treatment comprised both cognitive-behavioural techniques, aimed at alleviating the mood disorder, and neuroleptic medication. Success measured by reduced distress and reduced symptoms.

Table 2 Quality Appraisal

Citation	**Question/objective sufficiently described?**	**Study design evidence and appropriate?**	**Method of subject/comparison group selection *or* source of information/input variables described**	**Subject (and comparison group, if applicable) characteristic sufficiently described?**	**If interventional and random allocation was possible, was it described?**	**If interventional and blinding of investigators was possible, was it reported?**	**If Interventional and blinding of subjects was possible, was it reported?**	**Outcome and (if applicable) exposure measure(s) well defined and robust to**	**Sample size appropriate?**	**Analytic methods described/justified and appropriate?**	**Some estimate of variance is reported for the main results?**	**Controlled for confounding?**	**Results reported in sufficient details?**	**Conclusions supported by the results?**	**TOTAL Score:**
Askenazy, Lestideau, Meynadier, Dor, Myquel, & Lecrubier. (2007).	2	2	2	1	n/a	n/a	n/a	1	1	n/a	n/a	n/a	2	1	75%
Bartels-Velthuis, Jenner, van de Willige, van Os & Wiersma. (2010).	2	2	2	2	n/a	n/a	n/a	2	1	2	2	1	2	2	91%
Bartels-Velthuis, van de Willige, Jenner, van Os, & Wiersma. (2011).	2	2	2	2	n/a	n/a	n/a	2	2	2	2	1	2	2	95%
Bartels-Velthuis, van de Willige, Jenner, Wiersma, & van Os. (2012).	2	2	2	2	n/a	n/a	n/a	2	2	2	2	1	2	1	91%
Bartels-Velthuis, Blijd, & van Os. (2011).	2	2	2	2	n/a	n/a	n/a	2	1	2	2	1	2	2	91%

Best & Mertin. (2007).	2	1	2	2	n/a	n/a	n/a	n/a	1	n/a	n/a	n/a	1	1	71%
Brink, van Driel, el Bouhaddani, Wardenaar, van Domburgh, Schaefer, van Beilen, Bartels-Velthuis & Veling. (2019).	2	2	2	2	n/a	n/a	n/a	2	1	2	2	1	2	1	82%
De Loore, Gunther, Drukker, Feron, Sabbe, Deboutte, van Os, & MyinGermeys. (2011).	2	2	2	2	n/a	n/a	n/a	2	2	2	2	2	1	2	95%
Fujita, Takahashi, Nishida, Okumura, Ando, Kawano, Toyohara, Sho, Minami, & Arai. (2015).	2	2	2	2	n/a	n/a	n/a	1	1	2	1	2	2	1	72%
Maijer, K., Staring, T., Bartels-Velthuis, A. A., Palmen, S. J., & Sommer, I. E. (2020).	2	2	1	2	n/a	1	n/a	1	1	2	1	1	2	2	75%
Mertin, & O'Brien. (2013). Australia	2	2	2	2	n/a	n/a	n/a	2	1	1	0	1	1	1	68%
Steenhuis, Bartels-Velthuis, Jenner, Aleman, Bruggeman, Nauta, & Pijnenborg. (2016).	2	2	1	1	n/a	n/a	n/a	1	1	2	2	1	2	2	77%
Vickers, B. (2002).	2	2	1	2	n/a	n/a	n/a	1	n/a	0	0	0	1	2	55%

Appendix A

Child and adolescent mental health: Author's Guidelines

Author Guidelines

Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Ranked in ISI: 2014: 73/119 (Psychology Clinical); 93/140 (Psychiatry (Social Science)); 63/119 (Pediatrics); 75/133 (Psychiatry)
- 4000+ institutions with access to current content, and a further 5000+ plus institutions in the developing world
- High international readership - accessed by institutions globally, including North America (36%), Europe (41%) and Asia-Pacific (15%)
- Excellent service provided by editorial and production offices
- Opportunities to communicate your research directly to practitioners
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; rejection rate is around 84%
- Acceptance to Early View publication averages 45 days
- Simple and efficient online submission – visit http://mc.manuscriptcentral.com/camh_journal
- Early View – articles appear online before the paper version is published. Click here to see the articles currently available
- Authors receive access to their article once published as well as a 25% discount on virtually all Wiley books
- All articles published in CAMH are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF)

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice.

Original Articles: These papers should consist of original research findings.

Review Articles: These papers are usually commissioned; they should survey an important area of interest within the general field.

Measurement Issues: These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services.

Innovations in Practice: Submission to this section should conform to the specific guidelines, given in full below.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original article, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: **http://mc.manuscriptcentral.com/camh_journal** and c*heck for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal c*reate a new account.* Help with submitting online can be obtained from Prabha Choubina at ACAMH (e-mail **prabha.choubina@acamh.org**)

4. Authors' professional and ethical responsibilities

Disclosure of interest form
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**).

Informed consent and ethics approval
Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Note to NIH Grantees
Pursuant to NIH mandate, Wiley-Blackwell will post the accetped version of contributions authored by NIH grant-holders to PubMed Central upon acceptance. This accepted version will be made publicaly available 12 months after publication. For further information, see **www.wiley.com/go/nihmandate**.

Recommended guidelines and standards
The Journal requires authors to conform to CONSORT 2010 (see **CONSORT Statement**) in relation to the reporting of randomised controlled clinical trials; also recommended is the **Extensions of the CONSORT Statement** with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of

the main text, and in the online manuscript submission. Trials should be registered in one of the ICJME-recognised trial registries:

Australian New Zealand Clinical Trials Registry
Clinical Trials
Nederlands Trial Register
The ISRCTN Register
UMIN Clinical Trials Registry

Manuscripts reporting systematic reviews or meta-analyses should conform to the **PRISMA Statement**.

The **Equator Network** is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work **http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields** and on quasi-experimental **http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research** and mixed method designs **http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond**

CrossCheck
An initiative started by *CrossRef* to help its members actively engag in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employes a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Keywords: Please provide 4-6 keywords (use **MeSH Browser** for suggestions).

Key Practitioner Message: (in the form of 3-6 bullet points) should be given below the Abstract, highlighting what's known, what's new and the direct relevance of the reported work to clinical practice in child and adolescent mental health.

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.

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Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

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References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

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13. Footnotes should be avoided, but end notes may be used on a limited basis.

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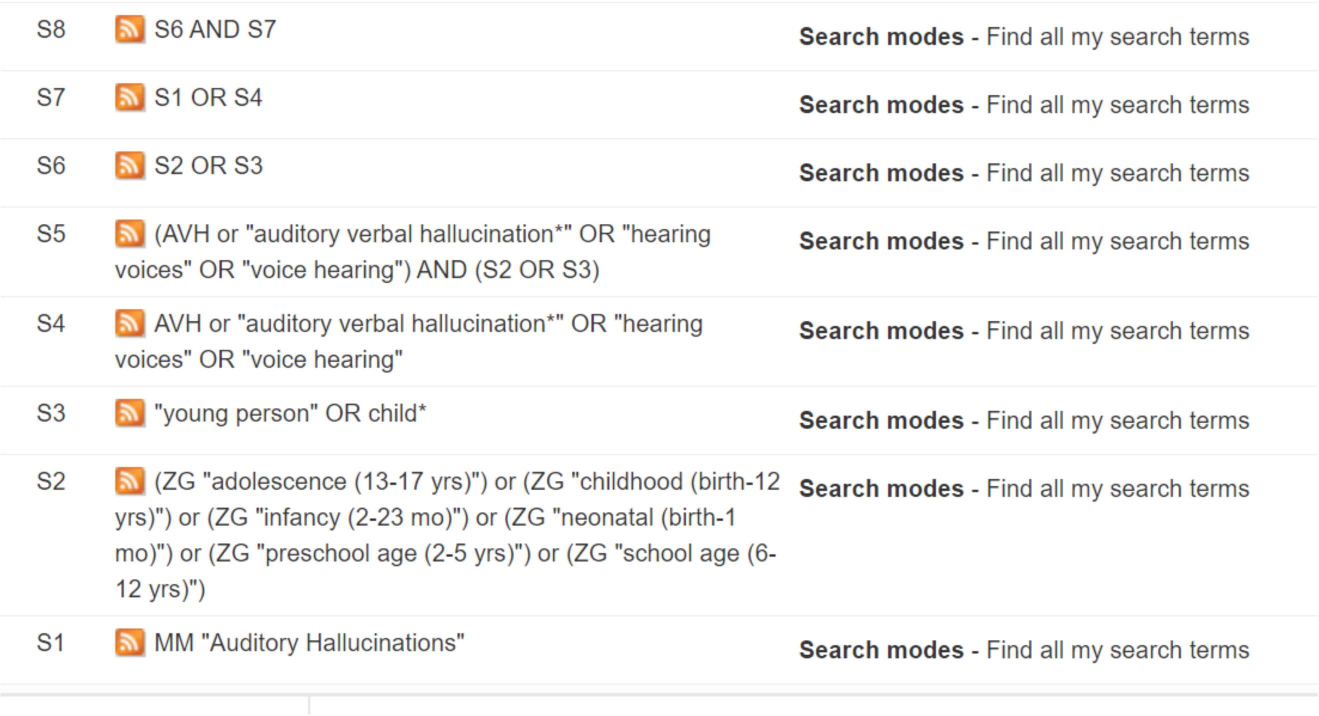
Appendix B

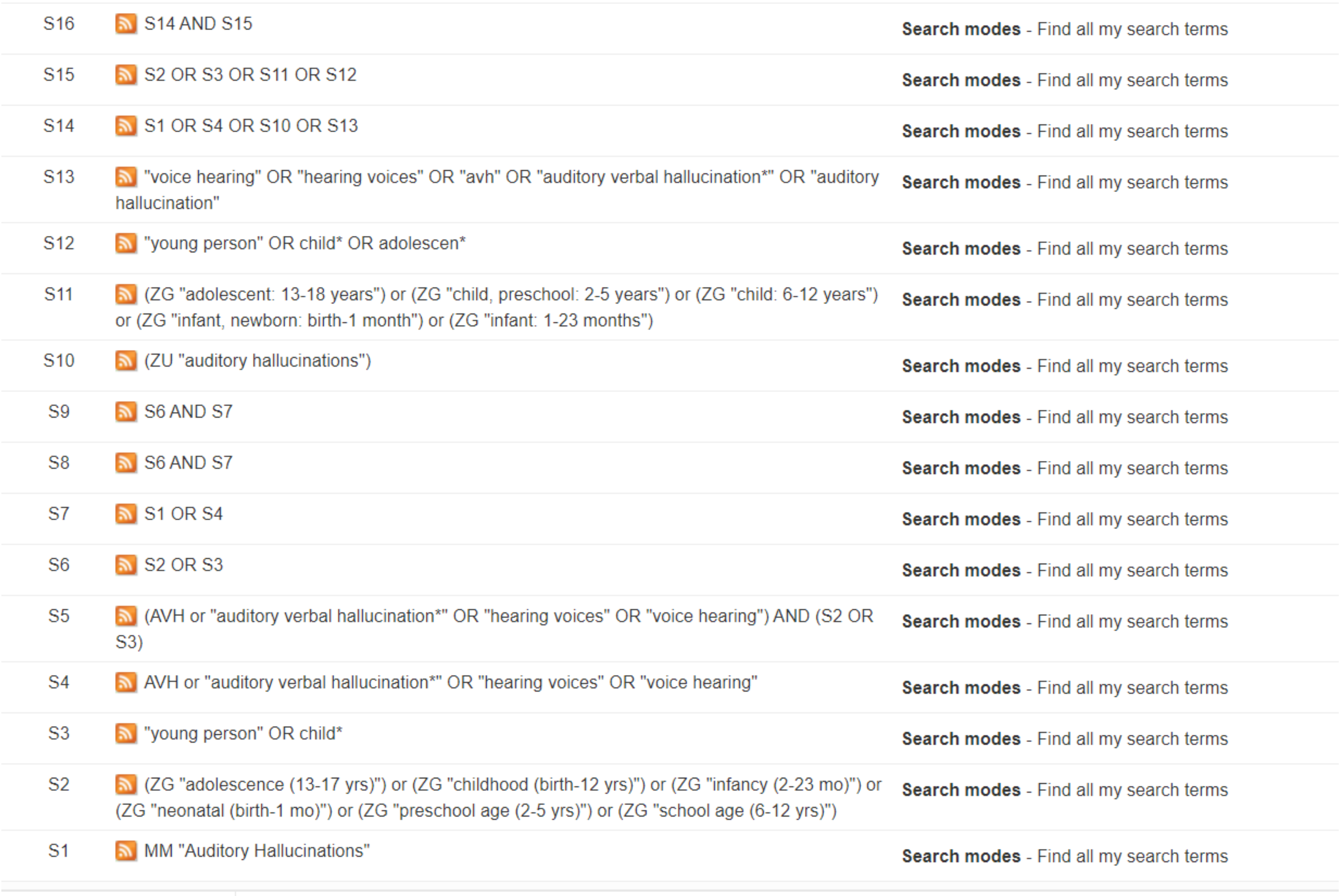
PsychInfo Search



S8	S6 AND S7	**Search modes** - Find all my search terms
S7	S1 OR S4	**Search modes** - Find all my search terms
S6	S2 OR S3	**Search modes** - Find all my search terms
S5	(AVH or "auditory verbal hallucination*" OR "hearing voices" OR "voice hearing") AND (S2 OR S3)	**Search modes** - Find all my search terms
S4	AVH or "auditory verbal hallucination*" OR "hearing voices" OR "voice hearing"	**Search modes** - Find all my search terms
S3	"young person" OR child*	**Search modes** - Find all my search terms
S2	(ZG "adolescence (13-17 yrs)") or (ZG "childhood (birth-12 yrs)") or (ZG "infancy (2-23 mo)") or (ZG "neonatal (birth-1 mo)") or (ZG "preschool age (2-5 yrs)") or (ZG "school age (6-12 yrs)")	**Search modes** - Find all my search terms
S1	MM "Auditory Hallucinations"	**Search modes** - Find all my search terms

Appendix C

Cumulative Index to Nursing and Allied Health Literature (CINAHL), Academic Search Ultimate, The Allied and Complementary Medicine Database (AMED), Medline Search



S16	S14 AND S15	**Search modes** - Find all my search terms
S15	S2 OR S3 OR S11 OR S12	**Search modes** - Find all my search terms
S14	S1 OR S4 OR S10 OR S13	**Search modes** - Find all my search terms
S13	"voice hearing" OR "hearing voices" OR "avh" OR "auditory verbal hallucination*" OR "auditory hallucination"	**Search modes** - Find all my search terms
S12	"young person" OR child* OR adolescen*	**Search modes** - Find all my search terms
S11	(ZG "adolescent: 13-18 years") or (ZG "child, preschool: 2-5 years") or (ZG "child: 6-12 years") or (ZG "infant, newborn: birth-1 month") or (ZG "infant: 1-23 months")	**Search modes** - Find all my search terms
S10	(ZU "auditory hallucinations")	**Search modes** - Find all my search terms
S9	S6 AND S7	**Search modes** - Find all my search terms
S8	S6 AND S7	**Search modes** - Find all my search terms
S7	S1 OR S4	**Search modes** - Find all my search terms
S6	S2 OR S3	**Search modes** - Find all my search terms
S5	(AVH or "auditory verbal hallucination*" OR "hearing voices" OR "voice hearing") AND (S2 OR S3)	**Search modes** - Find all my search terms
S4	AVH or "auditory verbal hallucination*" OR "hearing voices" OR "voice hearing"	**Search modes** - Find all my search terms
S3	"young person" OR child*	**Search modes** - Find all my search terms
S2	(ZG "adolescence (13-17 yrs)") or (ZG "childhood (birth-12 yrs)") or (ZG "infancy (2-23 mo)") or (ZG "neonatal (birth-1 mo)") or (ZG "preschool age (2-5 yrs)") or (ZG "school age (6-12 yrs)")	**Search modes** - Find all my search terms
S1	MM "Auditory Hallucinations"	**Search modes** - Find all my search terms

SECTION TWO

EMPIRICAL PAPER

‘I have finally realised I’m not crazy’: A narrative analysis of mental health and mediumship’

Amy Tomlinson

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count:

(Excluding tables, figures, reference lists and appendices)

Prepared for submission to: Mental Health Religion & Culture.

Abstract

Mediums are people who claim to communicate with the deceased. They generally report having good mental health; however, there is evidence that mediums have a high prevalence of trauma(s) preceding the development of their mediumistic abilities, and experience difficulties in making sense of their psychic abilities. A data set of 14 interviews with mediums originating from a qualitative, pluralistic project was re-analysed using narrative analysis to consider how unusual experiences develop over time and how these experiences come to be seen as mediumistic. Findings show that mediums experience trauma and build on previous research by demonstrating that attempts to fit in with social norms particularly around ‘healthy’ and ‘sane’ increases this trauma and distress. Participants sought out support from key figures and validating responses were key to them accepting and creating their identity as mediums. The study explores participants’ journeys to this point and discusses the implications for clinical practice.

This study forms part of a larger pluralistic project considering the experiences of mediums and their mental health. A data set of 14 interview transcripts was available for analysis with plans for the data to be analysed using three different qualitative methods: interpretative phenomenological analysis (described in the original Wilde et al, 2019 study); narrative analysis (the present study); and discourse analysis (to be conducted). By applying three different qualitative approaches to the same data set it has been argued that the benefit from the distinct insights that each method's analytical techniques is able to offer regarding the experiences of mediums will be maximised through consideration of individual meaning, societal meaning and linguistic contexts.

The initial study conducted by Wilde et al (2019), utilised an idiographic, phenomenological approach to try and gain an understanding of how mediums experience their mental health in relation to their mediumistic practice. Interpretative phenomenological analysis (IPA) allows researchers to explore phenomena from an 'insider perspective' (Conrad, 1987) and phenomenological studies seek to understand participants' internal worlds to interpret their cognitions, understandings and the meanings, valuing the participants' perspective of their own experiences (Smith, 1996). Whilst IPA is suited to exploring participants' understandings of their internal worlds, self, and identity, uncritically focusing upon such perspectives can sometimes overlook social and structural factors which influence personal individual experiences (Crossley, 2000). The majority of qualitative studies considering the experiences of mediums have used an interpretative phenomenological analysis (IPA) approach (Osborne & Bacon, 2015; Roxburgh & Roe, 2014; Taylor & Murray, 2012; Wilde et al., 2019) and it is hoped that through utilising a different analytical perspective further insights might be available.

Considering the wider context of mediums' experiences is particularly important as previous studies have highlighted the role of social and family environment, and participants' frame of reference, in accepting and understanding their experiences as mediumistic (Osborne & Bacon, 2015; Roxburgh & Roe, 2014; Taylor & Murray, 2012; Wilde et al, 2019). Furthermore, Temple and Harper (2009; as cited in Roxburgh & Roe, 2014) found that neophyte mediums often attended development circles to help manage negative or overwhelming experiences. Here, their experiences were given meaning and were culturally sanctioned, and mediums were taught techniques for controlling communication with spirits; such findings highlight how wider social narratives and meanings can influence individual experiences.

Narrative analysis is one alternative qualitative approach to IPA that considers the wider context of individual experience. Narrative analysis perceives individuals' accounts and narratives as a creative means of exploring and describing realities, which are arranged and bound in time (Frost et al, 2011). While interpreting the individual narratives, analysts also take into account the individual and cultural resources that are available to people at specific times, and which are used to construct their narratives, alongside the interpersonal or organisational functions of narratives (Atkinson, Coffrey & Delamont, 2003). McAdams (1985) argues that narrative is at the core of self-definition, and further, that identity is a life story. Within a narrative approach events and occurrences are taken to be experientially configured into a temporal whole with a beginning, middle and end, with a person's experiences of the present reciprocally informing their understanding of their past and future. Narrative analysis allows researchers to observe this meaning-making process.

Furthermore, as the stories that we tell are connected to, and limited by, cultural and societal narratives made available through media and other organisations with shared meanings and expectations, narrative analysis can also disclose how the social context contributes to individuals making sense of their experiences (McMahon et al. 2012). Utilising narrative analysis to examine the same data set as described in Wilde et al (2019) will allow for features which were not necessarily made available through using IPA to be identified.

Mediums are individuals who report being able to communicate with ‘spirits’ and the deceased via perceptions which are not available to others. These perceptions may include being able to see (clairvoyance), hear (clairaudience), or feel (clairsentience) the presence of the deceased, and other ‘spirits’ or guides (Rock et al., 2008). Within the West the prevailing view is that a person ceases to exist with brain death and there is widespread scepticism concerning mediums’ reported abilities (O’Keefe & Wiseman, 2005), although there are exceptions such as within specific religious and spiritualist cultures (Hunter & Luke, 2014).

There are similarities between several features of mediumistic experience and that of some people seeking treatment for mental health difficulties. Mediums’ perceptions of communication from the deceased are often similar to the phenomenon of hearing voices seen in some clinical populations (Peres, Moreira-Almeida, Caixeta, Leao & Newberg, 2012; Roxburgh & Roe, 2014; Taylor & Murray, 2012). The experience of ‘voice hearing’, labelled ‘auditory hallucinations’ or ‘auditory verbal hallucinations (AVH)’ within diagnostic terms, has historically been considered as a sign of poor mental health, with voice hearing often seen as a core feature of psychosis (Mawson, Cohen, & Berry, 2010). However, a growing amount of evidence has demonstrated that experiences such as hearing voices lie within typical experience (Bentall, 2000; McCarty-Jones, 2012). For example, research has documented that 75% of the general population have heard a voice or seen something that other people could not (Pechey & Halligan, 2012). Furthermore, approximately 10% of the population hear voices on a regular basis and only 30% of these contact mental health services (Romme & Escher, 2000).

Whilst mediums have reported initially having concerns about their mental health when their abilities first developed (Roxburgh & Roe, 2014; Wilde, Murray, Doherty & Murray, 2019), there is no evidence to suggest that mental health difficulties underpin or give rise to mediumistic abilities (Menezes Jr & Moreira-Almeida, 2011). While there is a high prevalence of traumatic life events among mediums, the evidence suggests they have positive psychological health and well-being (Moreira-Almeida, Neto, & Koenig, 2006). However, there is a potential for mediums to experience difficulties in the long-term in relation to their mental health as a result of their mediumistic work (Roxburgh & Roe, 2014; Wilde et al, 2019). For example, mediums have reported feeling spirits' ailments and causes of death as part of their clairsentience experiences (Rock et al., 2008; Roxburgh & Roe, 2014). Furthermore, in working with individuals who are bereaved they may be exposed to their distress (Newell, Nelson-Gardell, & MacNeil, 2016), yet do not have formal training to respond to such individuals or process the impact of such exposure on themselves.

Qualitative research using phenomenological analysis has proven useful in aiding our understanding of mediumship, exploring how mediums interpret and make sense of their abilities and perceptions of their role as a helping professional (Osborne & Bacon, 2015; Roxburgh & Roe, 2014; Wilde et al, 2019). Such studies have demonstrated the importance of how initial anomalous experiences come to be interpreted as signalling mediumistic ability and the impact of this interpretation on mediums' mental health. For example, Taylor and Murray (2012) found that how an individual appraises the event can contribute to their level of distress. Through selecting and engaging with positive voices, setting limits on contact with voices, and accepting the voices through a ‘frame of reference’ (mediumship and abilities), more meaningful experiences and more positive outcomes were reported.

Several studies suggest that the onset of voice hearing may be due to traumatic experiences (Hammersley, Dias, Todd, Bowen-Jones, Reilly, & Bentall, 2003). Within Roxburgh and Roe’s (2014) study, several participants spoke about early anomalous experiences such as hearing voices, prior to recognising these as mediumistic experiences, occurring following traumatic events. The initial anomalous experience could itself be experienced as traumatic, particularly for individuals who had no previous connections to mediumistic phenomena and therefore had less access to supportive or normalising explanations for their experiences. Furthermore, Andrew, Gray & Snowden (2008) compared a sample of mediums with a clinical sample of voice-hearers and found that, although both groups reported a high prevalence of traumatic life events, there was a higher prevalence of persistent psychological symptoms consistent with post-traumatic stress disorder among the clinical sample. This supports Wilde et al’s (2019) finding that mediums’ development of a normalising frame of reference and resilience in relation to their work may mitigate distress and mental ill health.

Additionally, Seligman (2005) suggests that the process of redefining one’s identity and the status and social support associated with the mediumship role serves a therapeutic function. This implies that normalisation and validation of distressing or unusual experiences contributes to positive well-being or better ability to cope. This premise is at the heart of the Hearing Voices Network (Styron, Utter & Davidson, 2017) who provide over 180 groups across the UK in which individuals who have lived experience of voices and visions can explore the meaning of their experiences in a validating and accepting environment (see www.hearing-voices.org).

Understanding the beliefs and experiences of mediums regarding their mental health difficulties is important in the same way as it might be for minority and religious groups (Menezes Jr & Moreira-Almeida, 2011; Wilde et al, 2019). The sense-making and experiences of these groups might differ from that of broader populations; for example, mediums may interpret the hearing of voices as part of their normal experience whereas this is often seen as a symptom of poor mental health within diagnostic frameworks (Peres, Moreira-Almeida, Caixeta, Leao & Newberg, 2012; Roxburgh & Roe, 2014; Taylor & Murray, 2012). Just as religious and/or cultural frames of reference might mediate mental health experiences or provide an interpretive lens for anomalous experience (Romme & Escher, 1989), so too might mediumistic understandings and frames of reference (Taylor & Murray, 2012; Wilde et al, 2019).

These understandings could help inform mental health professionals with regards to how to respond appropriately to and help mediums who seek help for mental health difficulties (such as trauma) without trying to change valued aspects of such experiences (such as their communications with the dead). Such understandings may also be beneficial for clinicians working with other individuals without mediumistic abilities but who report similar experiences (such as voice hearing). For example, understanding how mediums may live well with their experiences (and when they might need and seek help) could help inform interventions for individuals who do not (Taylor & Murray, 2012).

Method

Design

This study sought to explore mediums’ lived experiences of their own mental health throughout their lives, including in relation to their mediumistic work and that of their clients.

Narrative approaches consider the stories that people tell as important, that they signal the significant events of people's lives and reflect and reinforce social identities (Wong & Breheny, 2018). Approaching the topic from a narrative understanding embraces the historical nature of human experiences; narrative analysis uses retrospection as a way to find meaning that can't necessarily be found in the present (Freeman, 2015). Narrative analysis focuses on stories as a whole rather than grouping them into themes or abstracting them into discourses. As such narrative analysis considers multiple elements of storytelling as part of the analysis. This includes an evolving plot line, typically consisting of a beginning middle and end, the use of characters performing some kind of action and the role of the setting of the events (Wong & Breheny, 2018).

The Data Set

The narrative analysis was conducted on an existing data set collected for a qualitative, methodological pluralistic project (a project funded by the Bial Foundation; see Wilde et al., 2019). The data set consists of transcripts derived from interviews with 14 participants. Participants were all practising mediums who were not affiliated with spiritualist churches at the time of the interviews. They ranged in age and were predominantly female (see Table 1 for participant details).

[Insert Table 1]

The data set was collected via semi-structured one-to-one interviews (5 face-to-face, 4 via telephone, 5 using video-call). The interview questions focussed on participants' mediumistic abilities, time spent practising as a medium, and establishing how and when they used their abilities. For example, participants were asked 'Have your (mediumistic) experiences ever caused you problems, upset, distress, or affected your mental wellbeing in any way?; What did/do you do to cope with your experiences if you were/are upset or distressed?' All interviews were audio recorded and then transcribed verbatim. The mean length of interviews was 56 min.

Analysis

A narrative analysis was used to analyse the data in order to produce a composite story of the development of anomalous and mediumistic experiences over mediums' life span. The analysis was conducted based upon key principles of narrative analysis using guidelines proposed by Fraser (2004) and Andrews, Squire & Tamboukou (2008). The key steps in the analysis were:

- An initial reading of transcripts was completed to familiarise the researcher with the data, noting initial observations.
- Transcripts were re-read several times to produce a summary story for each participant. These stories summarised key events and characters, and noted significant thoughts and emotions associated with each temporal juncture.
- Individual accounts were then synthesised together through a process of comparison between stories, merging areas of commonality, and incorporating elements of participants' stories that illuminated or extended on others.
- The analysis produced chapters which summarised the key temporal junctures that characterised participants' composite stories

The analysis was focused upon narratives about mental health, anomalous / mediumistic experiences, and trauma and how or if these concepts were considered over time by the participants.

Reflexivity

In line with the social constructionist perspective, reflexivity (the awareness of the researcher's role in the process of research) draws light to the inseparability of observer, observation, and interpretation within research (Riessman, 2015). Reflexive detail regarding this study is provided here to help the reader to identify any possible biases through consideration of the author's own theoretical orientations and beliefs prior to data analysis. As this study involves a secondary analysis on an existing data set, the decision was made to not view the findings of the original study (Wilde et al, 2019) until after the analysis was complete. This was to try and limit any potential bias form viewing the previous analysis and findings.

The author had no direct experience of mediumship or anomalous experiences, however had extensive training in clinical psychology and has worked with individuals who have experienced such mediumistic or anomalous experiences as part of practising as a trainee clinical psychologist. Therefore, the author was aware of the potential for distress in relation to mental health difficulties and the tendency for some researchers and clinicians to pathologize experiences which could be seen as 'deviating from normal'. The use of qualitative methodology was chosen to privilege the voices and experiences of people who participated in this study.

Ethics

This study is a secondary analysis of existing data; in the ethical approval of the original study permission is in place for making anonymised transcripts from the original study available for analysis by other researchers and for using narrative analysis (FHM REC16001). Additional ethical approval was sought from Lancaster University Ethical

Approvals in order to meet the researcher's doctoral requirements (FHM REC18091). All data excerpts presented make use of pseudonyms to ensure participants' anonymity.

Results

Throughout participants' accounts multiple chapters were identified which characterise the common temporal junctures of their stories (Summarised in Table 2). Participants reported experiencing distressing life events including; bereavements, abusive relationships, life threatening accidents, and struggles with drugs and alcohol: "I don't think I've ever met a medium that hasn't had a shit life like me [LAUGHS] they've all got a story to tell along them lines." (Alistair). Participants varied in their depth of descriptions and the importance of these difficult experiences; alongside the role these events play within their narratives. How participants understood the concepts of difficult life events, mental health and mediumistic ability changed throughout their lives.

[Insert Table 2]

Chapter One – Introducing the unusual experiences

This is the earliest temporal juncture reported by participants, at this time the participants report their early encounters with the key character Mysterious Communicator (a character they would later recognise as spirits).

[Insert Figure 1]

There was a high prevalence of unusual events in participants' accounts, participants described experiencing unusual events or being open to spiritualism since childhood. Often participants framed these experiences as distressing life events. For example, Maddie described seeing dead people throughout her childhood: "Erm, and it was very very scary. I mean I'm; I was 3 then and I'm 52 now, and I still don't like sleeping without the light on". Alternatively, some participants mentioned experiencing traumas in their early life and how fleeing to a spiritual world or picking up on emotional undercurrents may have helped them to manage as described by Gina:

> I did have quite a traumatic experience when I was very very very young … I literally, because I couldn't physically escape the situation, I, I tried to escape and I actually left my body or something, but I knew that I was protected

Alongside this, participants who experienced unusual events in childhood described homes which were often chaotic, characterised by difficult relationships with family members and other potentially traumatic circumstances: "quite often you find that people who are going through these experiences have had some kind of trauma"(Beth).

For participants at this time the character of Mysterious Communicator was seen as a frightening and confusing character that often appeared in traumatic and chaotic environments. However, it was difficult for participants to determine whether these environments precipitated the arrival of communications from Mysterious Communicator or vice versa: "I can't say that was because of this ability, because I've always been like that, you know. It's like the chicken and the egg, I don't know which came first" (Mable).

Participants also recounted how others' responses to Mysterious Communicator could be punitive; consequently, participants learnt to hide these experiences from others "I didn't really know what it was. I just tried to forget it really. I didn't really talk to anyone about it." (Meg). Several participants described a period of 'fitting in' and wanting to belong. Participants recognised that the messages from Mysterious Communicator did not fit within the social norms and narratives available to them at this time. The desire to 'fit in' and feel similar to peers is often considered a priority within adolescence and helps to enforce desirable social characteristics. The decision not to disclose their experiences was with the aim of denying them “I just thought it was, I was just seeing strange things and I thought, oh well, forget it.” (Meg). The hope was that if they chose not to engage with the experiences they would not occur, and they would feel safer. “I just decided that I would be ordinary because it’s safer.” (Eileen)

At this time participants described their experiences as frightening, unexplained and socially unacceptable. When they attempted to communicate their experiences to others such as parents, they were often punished for this, leading to a reinforcement that their experiences were ‘wrong’ and they should try to supress them.

Chapter Two: Build up and break down: Struggling for a solution

The second key temporal juncture within the narrative describes a time when the appearance of Mysterious Communicator becomes more frequent and participants’ lives become more complex. The chapter explores the conflicts which arise when participants begin to try and fit the key character Mysterious Communicator into available societal narratives such as medical narratives of mental health. “I actually felt like I was being attacked by something and it used to cause me to feel very panicky, and extremely stressed. I actually felt like it’d be something that would just come at me out of the blue.” (Lisa)

Mysterious Communicator’s appearances were noted by participants to be more frequently around significant life events. The character also appeared stronger and harder to ignore: “as I got older, I was more aware of what was going on spiritually, like I could see more things and hearing things as well. Even smelling things. Like, and tasting things.” (Meg). Positive life events and transitions were also noted to lead to increased frequency for one participant “It became more kind of, whether I became more sensitive, because I’d had children, I don’t know. But it became, it was more frequent then.” (Mable).

For participants who did not report many interactions with Mysterious Communicator during childhood they described how they sought out spiritualism at a time in their lives when things were uncertain or subject to change. “Well my journey started when erm, my sister, who went to spirit world, not as a normal passing.” (Anne-Marie). Another participant (Jane) described attending a spiritualist church after a disastrous relationship: “somebody said to me, do you fancy coming to the spiritualist church and I was a single parent at the time and so I thought well, why not, you know, I’ll have a laugh” (Jane).

For all participants, the peak in experiences culminated in what many described as a ‘breakdown’: “when I got to 30, erm, I had a bit of a breakdown, and I actually had a psychotic episode.” (Maddie). Participants were no longer able to deny their experiences and needed to consider other ways to understand and manage these experiences: “they terrified me and I made a point, at that point, that I would do everything that I possibly could to not feel like that again.” (Freya).

At this time participants were no longer able to ignore Mysterious Communicator and so tried to fit the character into available societal narratives. As in chapter one they recognised their experiences did not fit within the societal view of ‘normal’ and so began to consider themselves as ‘abnormal’. Participants described concerns that they ‘might be going mad’ and that they wanted assistance to stop their experiences: “it scared me. I didn’t understand it. I didn’t understand what it was and erm, I thought that I was going mad.” (Maddie). These concerns reflect medical narratives around definitions of sanity and several participants described seeking counselling or medical support through their G.P., engaging and seeking help from actors with authority within medical narratives: “They kept coming and coming and coming and yes, I headed to the psychiatrist, going I'm crazy. I'm a nutty person." (Anna)

However, they found that these medical interventions did not reduce their experiences or improve their distress; whilst the character of Mysterious Communicator could fit within medical narratives as signs of 'illness' this structure did not provide a way to manage participants' distress. "Yeh I was given anti-depressants and they wanted to refer me to do CBT, which I did do a bit of but realised that they were only teaching me what I already knew really." (Beth).

Other participants described exploring religious beliefs and consulting religious leaders about their experiences, including seeking help through spiritualist churches and academies. As Gina describes below, she consulted key actors and leaders within religious and spiritual frameworks:

> that was one of my main reasons why I started studying metaphysical healing, Reiki, things like that because I did seek out a lot of guidance. I went to psychics and went to err, Shamans in, because I grew up in Africa, I went to Shamans and I went to ritual (Gina)

The consultation of authorities and key actors within both medical and spiritual narratives was a tactic employed by participants. Participants explored the societal narratives that were available to them, for Gina who grew up in Africa she consulted experts within her available societal narratives which included Shamans. For participants who grew up within the UK, they consulted medical authorities consistent with societal narratives around medical experiences and spiritual leaders within different churches.

It was during the period of turmoil and searching for explanations that participants came to consider Mysterious Communicator within a mediumistic framework. This understanding most often came from the suggestion of the key character Supportive Guide (see figure 2). The Supportive Guide could be relatives, friends, or professionals, the key characteristics of the Supportive Guide was that they encouraged participants to accept or welcome the character of Mysterious Communicator.

> I wondered what on earth was wrong with me, went to the doctor’s, was given some tablets for anxiety and stress and basically it didn’t go away. So, somebody told me about psychic attack, and I had every single symptom of it, and I thought, well it might be this, it might not. (Rose)

[Insert Figure 2]

Once participants had a chance to explore this explanation and consider Mysterious Communicator within a framework of mediumistic ability, they found that their encounters became less threatening and they had more control over Mysterious Communicator’s messages: “I’m not frightened of it now” (Freya). For participants finding an explanation for Mysterious Communicator which was open and validating allowed them to engage with this character differently, from a place of understanding and openness rather than fear or denial. “It gave me a safe environment to do that in, because the people that were around me, again were very open about it and open to it and didn’t look at things with sort of blinkered eyes.” (Beth).

During the second chapter participants described how they explored the idea of poor mental health as an explanation for anomalous experiences and the distress they experienced. Participants described their views about mental health changing over time as they came to understand their experiences as mediumistic and separate from poor mental health. Gina came from a religious background and spoke about how they came to accept their abilities as mediumistic:

> Well, they've changed in that I have finally realised that I'm not crazy and I don't have a mental health issue because my family did think I was crazy. They really did and erm, and everyone when it came down to the fact that my parents were divorced and I was emotional and all of that and yes maybe all of those traumatic experiences pushed me, sort of out of my body into my spiritual aspects of myself, to cope with it, but erm, you know, it's just a life that my soul chose

At this stage, participants began to recognise their experiences as distinct from mental health explanations, they also acknowledged the role of trauma and difficult life experiences in developing their abilities: "but I'm more self-assured these days otherwise I wouldn't have developed my psychic abilities. I'd have been too scared. And that was to do with me sorting out my own trauma, definitely." (Freya).

Chapter two details the journey shared by participants where they have reached a point where their anomalous experiences have become unmanageable for them. No longer able to supress or keep these experiences quiet they sought out advice and guidance from authority figures within their available narratives such as medical professionals and religious leaders. Their distress appeared to stem from being unable to find an 'acceptable fit' for their experiences, with fears they must be 'going mad'. It was only once they found a supportive narrative and validating reference frame that they began to consider their experiences as mediumistic.

Chapter Three: Obtaining control and maintaining well-being

Participants spoke about coming to terms with Mysterious Communicator and learning how to establish boundaries with the character. The method of opening up to spiritual energies and closing or shutting down when finished was a common method. Freya emphasised the importance of feeling safe: “I have crystals and I get, burn sage, to clear any negativity. I put some nice music on, and I feel safe.” Participants described how now they were aware of what was happening to them they were able to plan accordingly and take steps to manage their experiences. Some of the strategies described included an awareness of surroundings and potential vulnerabilities.

> I have to be aware of the fact that, if I’m walking around old buildings, you know, that I tend to avoid ruined castles and things like that, you know. You don’t put yourself in that position because I do a lot of paranormal work. (Maddie)

Participants described negotiating with Mysterious Communicator to set times or ways of experiencing messages to reduce their distress. “Yes. I’m in control all the time. All the time you are in control. And say they, they [Mysterious Communicator] want to work with us, and so they won’t, they won’t intimidate us.” (Anne-Marie). Another participant described how they would see messages in any reflective surface, after purchasing a crystal ball she was able to negotiate with Mysterious Communicator to confine them to this space, disregarding anything that came through elsewhere: “it was almost like a negotiation and erm, that that’s, I’m going to look at this for an hour every night and if you want to show me something, do it then.” (Anna).

Maintaining personal wellbeing was also recognised as part of developing strategies to gain a sense of control over their interactions with Mysterious Communicator: “I looked after my health, so I started taking care of what I ate and the people that I spent time with and so I became more conscious of my health on every level" (Gina).

This included taking breaks from practising when necessary:

> It was a difficult time and that's kind of why I put the psychic thing on the back burner for a long time. I didn't really start practicing again until my early 40s and I didn't want to. It was, hh, I just wanted to keep myself well actually. (Eileen)

In this time period participants have found an accepting narrative in which their experiences and the character Mysterious Communicator (now recognised as spirits or guides) can fit. They begin to explore their relationship with this character and start to work within this narrative to ensure their wellbeing and safety and to feel more secure.

Chapter Four: Embracing a mediumistic identity

At this temporal juncture the character of Mysterious Communicator has become an important aspect of participants' lives as participants begin to establish themselves as professional mediums. Maintaining a healthy lifestyle is considered an important part of living alongside Mysterious Communicator as does sharing their knowledge with others. Working as a professional medium brought participants into contact with clients, characters who, like the Supportive Guide, respond positively to participants' experiences and value participants' experiences.

The decision to create a professional identity focused on their mediumistic abilities appeared to come naturally to participants, once they had established some control and understanding of their interactions with Mysterious Communicator. Evie described how continued interaction with Supportive Guide helped her to develop her identity as a medium:

"what happens is, you meet like minds and it just snowballs really. You get involved and I then started to go to different little workshops and talks and started to explore my own abilities". Participants considered their abilities as skills and natural talents like any other which could be used to form a career: "Yeh. If you're good at plumbing you're going to make a living out of it. Just because you're good at it, you're not going to do it for free are you?" (Alistair). Using their abilities to help others was seen as valuable by all participants who described starting to use their abilities slowly.

> I've always been curious and when you start to try one particular like, a colleague at church, and they say, oh that really makes sense, that means something. Then, you know, you'll do the next one, and then somebody else'll pass over and bit by bit, you get the confidence. (Jane)

Participants varied in age and experience as professional mediums and so a broad range of professional identities were captured in their accounts. Most participants worked more than one job when beginning as a medium or psychic, often in similar healing or caring roles such as a nurse or reiki practitioner: "so, I was doing readings, healing before I went to work and I'd do an 8 hour shift at work, and then I'd come home and I'd do another class of people for readings, healing and that's how it started." (Anne-Marie). The practice of establishing their abilities and developing control through boundaries naturally required interaction with Mysterious Communicator and practising their abilities to do so. Participants described feeling empowered when they were given positive feedback from clients and feeling affirmed when given evidence that they were correct: "Most of my clients come from recommendations or they're repeat business. So, as that grew and developed, I started really believing that this was actually being put there. I wasn't just imagining it." (Beth)

Participants spoke of gaining further training in counselling or study of metaphysical studies to broaden their knowledge and improve their practice. “I did a counselling course, because I didn’t want it all to be home spun philosophy and I was part way through a theology degree.” (Anna). Participants took their responsibilities seriously and also considered ethical and practical issues related to working as a medium.

> I even got a diploma in counselling because I recognised that I’m dealing with people when they are at their most vulnerable and I think when you work in this field, you, you have to take your responsibilities very seriously. (Maddie).

Participants became more active in their experiences after finding a frame that allowed them to establish control and through using their experiences as part of daily working life found distress reduced “it doesn’t really affect me as an individual anymore because I am in control.” (Maddie).

Alongside developing a professional identity through practising as mediums participants also further developed their skills at managing their own health and wellbeing whilst interacting with Mysterious Communicator. Freya explained how it could be difficult for mediums who practised a lot to keep taking care of themselves: “your focus is not on yourself in your body because you’re connected to everybody else all the time, and erm, self-care can go out of the window. People can get really poorly.” (Freya). Alistair stated that for some people work as a medium could be used to ignore their own difficulties by focusing on others: “Yeh. I know a few which suffer and are bipolar, yeh. And I do find that it can be used as an excuse to not deal with life’s issues.” (Alistair).

Working as mediums exposed participants to multiple encounters with Mysterious Communicator, which over time could be draining physically and emotionally. “if I do a show, I’m absolutely exhausted. It’s very draining” (Maddie). On the other side participants also spoke about how if they stopped using their abilities for work the energy could begin to build up again and spill over into their personal life, with Mysterious Communicator making contact more frequently or outside of negotiated terms: “Because I now use it for work, it’s controlled. If I didn’t, if for some reason I had to stop using it … the energy would kind of build-up and it would then break through into my life” (Anna).

The main concern for participants at this stage was remaining safe whilst practising and ensuring their spiritual and physical health was maintained. “Erm, and I’m aware that I could only do my psychic work and feel safe, once I was taking care of myself on a spiritual level.” (Freya).

Within chapter four participants are no longer searching for an authority figure and instead have established themselves as a key figure within their own narratives. They are able to receive validation from others and provide guidance to those who seek it. Maintaining health and a positive relationship with the Mysterious Communicator remains important however they are less distressed by their experiences and confident in their abilities.

Chapter Five: Living as a medium; consolidating identity and navigating societal narratives.

This temporal juncture highlights the end of the narrative, it was the present at the time of the interview. Participants are able to reflect on their narratives and consider key characters and events through their current perspective. Navigating the world and societal narratives remains difficult at times, however conflict is no longer within the participants or with Mysterious Communicator but located in others. All participants came to accept their mediumistic abilities as part of their identity. They recognised it as something that had always been with them and when looking back over their lives, they interpreted events through this framework "It doesn't worry me or, very rarely anyway. It very rarely upsets me or worries me, and I just accept it as part of the world that we all live in, not just me." (Eileen).

Judgements of other people could impact them negatively "I've had, I've had abusive mail. Threats. All sorts put through my door" (Maddie); with several participants describing themselves as counsellors when asked what their profession was: "sometimes I just used to say I work as a counsellor, or a therapist because it's easier" (Jane). However, unlike their earlier years this denial was to prevent discussions or to avoid offence rather than to deny the internal aspect to themselves. Participants stated they did not want to convince others of their abilities or offend anyone with their beliefs. "Well it's not my job to convince them. I don't care if they don't believe. Fine, you don't believe." (Anna). They were comfortable with their abilities and themselves and felt honoured with the responsibility of communicating with Mysterious Communicator: "Because it gave me, I felt responsible, absolutely. Because I knew what was happening and I knew that I wanted to connect to where it was at with people" (Freya).

As participants came to see mediumship as part of their identity and their experiences as innate gifts, they also shifted their relationship with mental health. Participants were able to accept wider societal discourses around mental health however no longer struggled to fit Mysterious Communicator into this framework.

> looking at it now is completely different to how it was when it was mental illness, in my expec, my view of it then, was clearly I'm mentally ill because it was the whole fear of mental health more than the fear of, you know, what I was seeing and that. (Anna).

Participants defined mental health in relation to their own experiences, those who had difficult or unhelpful experiences of mental health services in relation to contact with Mysterious Communicator were more likely to question whether mediumistic abilities were being misdiagnosed in others and had doubts about the usefulness of the system. Conversely, participants who had contact with mental health services in relation to other experiences not related to their medium abilities, considered the explanation of mental health to be separate but a valid construct. For example, Evie spoke about her views on narratives of mental health and her relationship to this construct: "there's a difference in that my mother-in-law was a schizophrenic and she suffered with great periods of paranoia, and those voices that she had were totally different to the voices that I know."

Another participant described struggling with their mental health previously and how different the experience was to their mediumistic experiences.

> But there's a world of difference. When I'm teaching, I always say there is a very [thin] line between psychic and psychotic. And actually, having had a psychotic episode, hh, I've walked that line personally and so I do understand it. (Maddie).

One of the participants recounted how overcoming a traumatic event allowed them to heal, and how it was after this they were able to develop their ability: "I was counselled and obviously, well what happened with my sister, I had to go through all that and then, but then the healing took effect then as well" (Anne-Marie).

For this participant mediumistic abilities were a way to help others to heal and come to terms with trauma or mental health difficulties by trusting the mind and spirit. This was a view also shared by other participants, that their abilities and communications from Mysterious Communicator could help others to heal from the effects of an unkind and unaccepting world. “Healers help heal the body and psychics help to heal the heart. I do believe that, you know. That’s what’s important about it for me.” (Eileen). Participants were able to fit themselves and Mysterious Communicator into wider social narratives about healing, expanding beyond medical explanations to also include spiritual healing.

All participants described their belief that their experiences were not caused by mental health difficulties but could instead lead to poor mental health if managed incorrectly or if judged as such by others: “the person who’s sensitive breaks down, has a nervous breakdown, or has a mania, or something, … then they’re the one labelled with a mental health issue” (Gina).

Within this reflective chapter participants are able to provide their reflections on their journey and comment on the differences in their views and approaches at different times within their narratives. As an authority figure within their community they provide the guidance and knowledge of the societal structure that they once sought when they struggled to find an explanation for their experiences.

Discussion

Participants’ narratives of their mediumistic experience describe similar journeys from potentially distressing interactions with the key character Mysterious Communicator to gaining agency and control over their experiences and incorporating these into a professional identity to share with others. This study aimed to understand any trauma which may precede mediumistic abilities, the development of these experiences and the development of mediumistic identity and how they are subsequently adjusted to and/or coped with over time. In line with previous research participants reported traumatic experiences prior to and around the time of anomalous experiences (Hammersley, et al, 2003; Roxburgh & Roe, 2014).

Participants who had no previous knowledge or reference frame of mediumistic phenomenon were more likely to find the initial anomalous experiences distressing and sought to reduce their stress by hiding and denying their experiences to conform to societal narratives regarding sanity / healthy experiences.

This study builds upon the one conducted by Wilde et al (2019) through the utilisation of a narrative approach. Narrative approaches consider the stories that people tell as important, that they signal the significant events of people's lives and reflect and reinforce social identities. Therefore, this study is able to provide additional insight into how mediums might navigate the process of establishing identity over time. By using a temporal structure, the narrative analysis is also able to consider the evolving relationship between participants and the Mysterious Communicator (their anomalous experiences / communications with spirits and guides). There is evidence to suggest that individuals who hear voices develop relationships with these which can affect whether they find these experiences to be distressing or positive (Parry & Varese, 2020) and understanding how these relationships may develop over time could be useful in supporting individuals who have these experiences.

The findings reported by Wilde et al (2019) detail how participants came to terms with their past experiences of trauma and were able to utilise their experiences to inform their mediumistic practice and identity. While they note the difficulties experienced by some participants in receiving helpful support through mental health services this is framed as an individual problem – that mediums perceive negative attitudes and found the experience unhelpful. Through considering a wider narrative approach, this study is able to detect a recurring pattern within participant narratives, of seeking validation and support from key figures within an available societal frame, and the distress experienced when their experiences are denied, punished, or seen as undesirable.

The use of IPA in Wilde et al' study allows for exploring the personal meanings of mediumistic identity for participants. However, within this narrative analysis the social position and power structure elements became more apparent with participants becoming more confident and secure in their identity then using this to provide the guidance and support others seek from them. Alongside this the study highlights how the external validation and support of the Supportive Guide was important in helping participants to find a safe social framework for developing their talents often with the support of a mentor or development group. Overall, the two analyses of this data are complementary together detailing how mediums might come to terms with their experiences over time and how available social networks play a role in this.

The analysis identified a key response pattern of seeking out validation and support from leading figures and key actors within the societal narratives available to participants; alongside, their attempts to fit Mysterious Communicator within these narratives. This pattern was seen throughout participants' narratives, with different key actors and societal narratives identified at different temporal junctions. For example, within chapter one during participants' early childhood, participants spoke about telling parents (arguably a key actor and authority figure of early childhood) about their experiences. This was often met with dismissive and punitive responses, which informed participants' responses of hiding and denying their experiences to conform to societal narratives regarding sane/healthy experiences.

Similarly, this response was also seen in early adolescence when participants described being bullied by peers due to their experiences and choosing to hide their perceptions from others. During the second key temporal juncture participants described an increased frequency of traumatic experiences and how their current strategies of denial were no longer viable therefore they sought out alternative explanations and narratives. Participants' accounts at this junction describe how they sought guidance and support from key actors in the wider societal narratives that were now available to them, including doctors and religious leaders, before being guided towards mediumistic understandings of anomalous experiences by a key character of Supportive Guide.

Participants searched for meaning and answers as a way to reduce distress. Several participants described how it was the uncertainty of their experiences and a 'fear of going mad' rather than the anomalous experiences that caused distress. This highlights the importance of shifting societal narratives around the experience of hearing voices and other anomalous experiences. If these key actors within these narratives were able to respond in a manner similar to the Supportive Guide; validating participants' experiences and encouraging them to work with their experiences rather than deny them, then participants may have been able to reduce their distress and establish a better relationship with Mysterious Communicator at an earlier time frame (Hammersley, et al, 2003).

In line with previous research (Osborne & Bacon, 2015; Taylor & Murray, 2012; Roxburgh & Roe, 2014; Wilde et al, 2019) the findings of this study highlight the importance of a cultural frame of reference for participants' experiences. It was through viewing their experiences as being within mediumistic phenomena which allowed participants to feel some sense of agency and control over these experiences and reframe their earlier narratives of 'going mad' or distressing / traumatic experiences into a sign of mediumistic ability and gift. This finding was built upon in this study as participants' narratives detailed their developing relationship with spirits and guides (Mysterious Communicator) throughout their lives. While attempting to fit their experiences into societal narratives was a cause of distress it is important to note that the communications themselves could feel overwhelming and distressing (for example seeing dead people or feeling drained) and it was when participants began to interact with these communications in a more positive and accepting light that they began to negotiate and establish boundaries with the spirits.

The time period in which participants began to establish their identity as mediumistic is highlighted within the analysis as a time when participants were able to feel safe exploring their experiences and learned to trust their intuitions, thanks in part due to other supportive characters and positive feedback from others. This approach of positive engagement with voice and anomalous experiences has been noted to reduce individuals' distress and has also been used as a basis for therapeutic input within mental health services and wider (e.g. Hearing Voices Network, Styron, Utter & Davidson, 2017; Talking With Voices, Corstens, Longden, & May, 2012).

The role of stigma and distress related to anomalous experiences is well documented as is the differences between cultures and the 'negative' perception of these experiences (Yang, Wonpat-Borja, Opler, & Corcoran, 2010; Hunter & Luke, 2014). Wider societal shifts in the perception of anomalous experiences away from those of 'different' or 'wrong' towards a more accepting and validating stance would help to inform the views of others and may help to reduce distress for those who have these experiences. For example, children who experience voice hearing are likely to benefit from input with their family around psychoeducation about voice hearing and normalisation of their experiences (Maijer, Staring, Bartels-Velthuis, Palmen, & Sommer, 2020). As research moves towards a continuum model of unusual experiences it is hopeful that more accepting and validating views may become more mainstream.

Numerous participants had experiences with mental health services as part of their narrative; these experiences were typically described as unhelpful. However, it is important to note that at these times participants were still looking for their experiences to be taken away, it was not until later that participants began to accept their experiences and look for ways to live alongside them. For participants at this time a more validating and normalising approach from mental health services may have been more beneficial than attempts to deny or suppress their experiences (Hammersley, et al, 2003). Indeed, two participants who described positive experiences in accessing support services indicated that they benefited due to these services being supportive and validating.

Participants differed on their views towards mental health and mediumship. For some there were clear distinctions between their mediumistic experiences and other anomalous experiences, whereas others described concerns that some individuals may have been misdiagnosed or treated by medical models. However, all participants described using strategies to manage their experiences which mirror those used to manage mental wellbeing in general (Government Office for Science, 2008).

Clinical implications

The narratives discussed in this study reflect how mediums are likely to have experienced previous trauma and are likely to come into contact with mental health services. Furthermore, participants' narratives show that it was a fear of 'being mad' and not fitting into wider societal narratives of being 'sane' which caused the most distress. This research highlights that it is essential to consider how medical models and societal/cultural narratives might be threatening to individuals who experience anomalous events and the importance of considering an individual's past experiences of mental health services and their beliefs about their experiences in order to provide validating and empathetic care.

Practising mediums have a range of good skills for managing their wellbeing and experiences which could be drawn upon. These strategies could be learned from and drawn on in adapted therapy for supporting people to manage anomalous experiences. For example, skills-based training including strategies that aim to help individuals with pacing their activities to their current energy levels, monitoring their wellbeing and resilience, having access to appropriate soothing and relaxation strategies could help individuals to manage their experiences. Furthermore, the importance of having supportive colleagues, families and communities was a key finding within this study. Supportive interactions with therapists and other individuals with similar experiences could be beneficial in providing a supportive and validating environment.

Furthermore, this study highlights how individuals who have anomalous experiences and contact mental health services may be looking for a way to continue to deny or suppress their experiences. This can result in an increase in distress and further anomalous experiences as individuals continue to feel ‘unsafe’ or ‘going mad’ as stress and suppressed emotions increase, creating an unhelpful feedback loop of attempted suppression, increased distress, increased anomalous experiences and increased attempted suppression. As clinicians it is important to consider how we might help individuals to accept their experiences and adjust their goals and expectations when appropriate. Acceptance and Commitment Therapy (ACT) and Compassion Focused Therapy (CFT) are therapeutic approaches with an emphasis on accepting the circumstances individuals find themselves in and increasing self-compassion in the face of human struggle. These approaches might be suitable for individuals who have anomalous experiences as they aim to improve quality of life and reduce distress without focusing on a reduction of anomalous experiences which can be important to individuals’ identity and provide positive effects.

Conclusions

This study utilised narrative analysis to explore the mental health of mediums, aiming to develop an understanding of how health professionals might support individuals who seek help without denying these experiences. The main findings support previous research that mediums are likely to have experienced high levels of trauma. Building on previous studies this research demonstrates that participants' distress was related to wider societal norms around what is considered 'healthy' or 'sane'. Attempting to 'fit in' to these societal structures by way of hiding or denying their experiences often led to further psychological distress. Participants often sought alternative explanations by consulting figures of authority within different societal narratives (e.g. parents, doctors, and religious leaders). These experiences could be unhelpful due to the invalidating approaches taken. Once participants found a supportive guide who provided a validating and normalising approach to their experiences, they were able to develop strategies to manage their experiences and develop their mediumistic identity within a welcoming and accepting cultural frame. This highlights the need for health professionals to consider cultural frames of reference when supporting individuals in clinical practise. Furthermore, this work should consider their past experiences, be considerate of their beliefs and draws on the strengths and skills they have already.

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Figure 1 : Box 1

Box 1 Key Character – Mysterious Communicator

Mysterious Communicator is a key character reflected throughout participants accounts. This character represents the source of the anomalous experiences described by participants. As participants did not initially describe these communications as being from spirit or the deceased referring to the character as a mysterious communicator allows for the initial confusion and sense of external forces described by participants alongside later understandings of the anomalous experiences as deliberate messages coming from spirits, guides and the deceased. The character is described as a mysterious communicator to encapsulate the different ways in which participants described receiving communications from spirits such as through visions, voices or feelings. The main features of this character are that they communicate only to the participants, and they appear throughout the narrative. The ways that participants relate to this character changes throughout their narratives and this is reflected within each chapter. Participants early encounters with Mysterious Communicator are described below.

“My first awareness I was about 6 or 7 years old and it was a vision. A full, solid as you and I are. I was going to school and a building had appeared”. (Anna)

“Well I first started knowing things and hearing thoughts that came through when I was about four and it’s just been with me ever since”. (Rose)

“Well I know I had an imaginary friend as a child and erm, I think that that’s very much where it’s kind of started and starts for most people”. (Eileen)

Figure 2 : Box 2

Box 2: Key Character - Supportive Guide

This character encouraged participants to reinterpret potential mental health issues through an open-minded perspective. They provided an alternative lens through which participants could view their experiences. This character's relationship to participants varied from health professionals, to family members, to future teachers and mentors. Throughout participants narratives they are described as encouraging, open to alternative explanations, like-minded and suggesting rather than enforcing. Some examples are given below.

"A spiritualist church, yeh. And I was sat in the circle. I had been sat trying to understand it and develop it and everybody had told me I was a medium and I was, well what's a medium?" (Alistair)

"Erm, and she gave me that safe space and helped me learn how to interpret it all." (Eileen)

"So, she was doing me a tarot reading and it was amazing, and I knew she'd got my sister with what she was telling me, and then afterwards she said, *would you like to come back*. She said, *you've had such a trauma. I've got somebody coming over from France,* and she was a trauma healer, and I thought, oooh, I'm not sure about this. So, I said, *fine, yes I'll experience it then*." (Anne-Marie)

"I must have been 19, and I was very very lucky that I found a lady called [name], who lived in [place], because that's where I lived at the time, and she kind of took me under her wing" (Maddie)

"as I got older and older, into my early 20s, erm, I started going to this place in [name of place]. …….. It was so fun, and you just, and she helped me develop it a bit more" (Meg)

"my eldest brother, erm, was a really good support and he was into the psychic. Well he'd been to a couple of psychics. He said, *why don't we go and see this woman and see what she says. Maybe she'll, you know, tell you, you know, something that's useful*." (Anna)

Table 1 Participant demographic details

Table 1. Participant demographic details

Participant Number	Pseudonym	Age	Sex	Years' experience as a professional medium	Interview Method
1	Freya	46	Female	15	Face to face
2	Jane	49	Female	9	Face Time
3	Anna	50	Female	28	Face to face
4	Mable	62	Female	15	Telephone
5	Gina	37	Female	5	Skype
6	Eileen	63	Female	20	Telephone
7	Anne-Marie	49	Female	12	Face to face
8	Maddie	52	Female	15	Skype
9	Meg	25	Female	2	Face to face
10	Lisa	38	Female	9	Face to face
11	Rose	45	Female	3	Skype
12	Evie	43	Female	15	Skype
13	Alastair	41	Male	10	Telephone
14	Beth	45	Female	15	Telephone

Table 2. Results Chapter Summary

Chapter Title	Summary
Chapter One: Introducing the unusual experiences	This is the earliest temporal juncture reported by participants and where we join this narrative. Generally occurring in childhood, at this time the participants report their early encounters with the key character Mysterious Communicator.
Chapter Two: Build up and breakdown: Struggling for a solution	The second key temporal juncture within the narrative describes the conflicts which arise when participants begin to try and fit the key character Mysterious Communicator into available societal narratives such as medical narratives of mental health.
Chapter Three: Obtaining control and maintaining well-being	The third chapter details the temporal juncture at which participants begin to actively negotiate and engage with Mysterious Communicator to allow for more positive interactions with this key character.
Chapter Four: Embracing a mediumistic identity	The character of Mysterious Communicator has become an important aspect of participants lives as participants begin to establish themselves as professional mediums. Maintaining a healthy lifestyle is

	considered an important part of living alongside Mysterious Communicator as does sharing their knowledge with others.
Chapter Five: Living as a medium; consolidating identity and navigating societal narratives.	This temporal juncture highlights the end of the narrative, it is the present at the time of the interview. Participants are able to reflect on their narratives and consider key characters and events through their current perspective. Navigating the world and societal narratives remains difficult at times, however conflict is no longer within the participants or with Mysterious Communicator but located in others.

Appendix A

Author Instructions for Journal Mental Health Religion and Culture

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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SECTION THREE

CRITICAL APPRAISAL

Amy Tomlinson

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count: 2625

(Excluding tables, figures, reference lists and appendices)

In this critical appraisal, I will detail an initial summary of the main findings from both the systematic literature review and the empirical paper. I will then expand on some of the limitations of this research, including the difficulties in defining key terms and the use of secondary data.

Summary of empirical paper

The empirical paper completed as part of this thesis utilised a narrative analysis to consider a data set of 14 interview transcripts. The interviews were conducted with practising mediums, individuals who report communicating with the deceased either directly or through spirits and guides. The interviews were focused on gaining further understanding of the mental health of mediums. Mediums generally report having good mental health; however, there is evidence that mediums have a high prevalence of trauma(s) preceding the development of their mediumistic abilities, and experience difficulties in making sense of their psychic abilities.

The analysis created a narrative consisting of five chapters: Chapter One: Introducing the unusual experiences, Chapter Two: Build up and breakdown: Struggling for a solution, Chapter Three: Obtaining control and maintaining well-being, Chapter Four: Embracing a mediumistic identity, and Chapter Five: Living as a medium; consolidating identity and navigating societal narratives. The findings suggested that mediums often experience trauma prior to and following the development of their abilities and builds on previous research by demonstrating that attempts to fit in with social norms particularly around ‘healthy’ and ‘sane’ increases this trauma and distress. Participants within this study sought out support from key figures and validating responses were vital to them accepting and creating their identity as mediums.

The study highlighted the importance of considering individuals' beliefs and experiences in clinical practice and suggests that the use of acceptance and normalisation as well as validation of experiences may be most helpful in supporting those who experience distress as a result of their experiences.

Points of discussion relating to Empirical Paper.

Secondary analysis

I would first like to acknowledge and thank my research supervisor Dr Craig Murray for his assistance in getting this project approved and developed. The use of pre-collected data for my doctoral thesis was reviewed and approved by the course's programme director and thesis co-ordinator. The initial driving force behind the use of this data was that I had been recently (2017) diagnosed with Chronic Fatigue Syndrome, and this affected my ability to conduct the interviews necessary to acquire first-hand data. My supervisor had access to a data set which was available for secondary analysis using narrative or discourse analysis as part of a planned methodological pluralistic project, and ethical permission was in place for the use of this data in this way.

Pluralistic analysis (wherein the same data is analysed using different analytical approaches) considers the different forms of knowledge gained through the use of diverse methods of analysis as complementary, each reflecting a different aspect of the phenomenon of interest (Clarke, Willis, Barnes, Caddick, Cromby, McDermott & Wiltshire, 2015). It has been argued that utilising multiple analytical perspectives allows for the maximum amount of information and interpretation to be gained from the data (Coyle, 2010). However, there remains a debate around the use of pluralistic approaches. There are concerns that approaches which are incompatible may make the respective findings obsolete, or if approaches which are compatible provided sufficient ‘added value’ from the analysis (Clarke et al, 2015).

Some of these concerns around the use of pluralistic approaches are mitigated within this empirical paper. Although using data created from a pluralistic project the study was designed as independent from this for the purpose of meeting doctoral requirements. Consideration is given within the empirical paper to Wilde, Murray, Doherty, & Murray, (2019) who had published results from the first of the series of pluralistic papers, using an Interpretative Phenomenological Analytic Approach (IPA). However, this paper was only reviewed after concluding the narrative analysis detailed in the enclosed empirical paper.

Narrative analysis

As the data included in the study was pre-existing and not collected by the researcher, arguably some central aspects of the narrative analysis process were not able to be fully achieved. Firstly, an important step in the narrative analysis is the interview itself, with Fraser (2004) recommending that the emotional tone of the interview be noted and recorded to prevent over intellectualisation of the data. Due to the method of data collection chosen for the empirical paper this was not possible and consequently, may have limited the understanding gained from the transcripts.

Secondly, as noted in the empirical paper, it was not possible to contact the participants who took part in the interviews to collaborate and share the interpreted narratives with them, as you would perhaps expect in Narrative Analysis (Andrews, Squire, & Tamboukou, 2008). This was because whilst ethical permission was in place to use the anonymous transcripts in other analyses, the participants had not consented to being contacted for the purpose of future research. A central element of narrative analysis is considering the key junctures and time periods captured in the analysis, understanding the social and personal meanings they capture (Fraser, 2004). Without the feedback from participants the analysis is more open to bias from the researcher (the author) and it is possible that my own experiences, beliefs and preference for certain narratives influenced the analysis.

Attempts were made to counteract these limitations. Records of key decisions and reflections on the summarised stories for each participant were kept in an effort to reduce bias. Chapters of the narrative produced were shared with my research supervisors for feedback and comments and discussed further to help elicit as many potential meanings and narrative threads as possible.

Position on mediums

In considering the topic of mediums I noticed a general trend within the research literature, broadly categorising this research into the following groups: those that wish to test mediums' abilities to gain 'proof'; those which are sceptical and consider what makes mediums believable; those which consider mediums as 'non-clinical voice hearers' on the spectrum of psychosis; those which consider mediums' cultural position e.g. as healers or professionals. There was a tension for me when considering these groupings; as a trainee clinical psychologist who needed to demonstrate the 'clinical relevance' of a thesis topic considering mediums as being part of a 'continuum of psychosis' had potentially the most personal value. However, this also conflicted with personal values more consistent with clinical psychology; that an individual's beliefs be respected and that diagnostic categories were less helpful than consideration of distress. It was in considering mediums as members of a religious or cultural sub group that I was able to refocus on mediums as a population with less wider considerations of 'voice hearing'; looking instead at their experiences, how these were described and narrated by participants and the effects of these on their mental health.

This approach to the subject of mediumship however became more difficult when considering the literature review. With so few studies explicitly considering mediums, and recent reviews which already considered the experience of mediums (Bastos Jr, Bastos, Gonçalves, Osório, & Lucchetti, 2015), I needed to branch out to a related topic and once more confront the idea that ‘voice hearing’ might be seen as the same as mediumship (Peres, Moreira-Almeida, Caixeta, Leao & Newberg, 2012; Roxburgh & Roe, 2014; Taylor & Murray, 2012). As someone who is ambivalent in their own views of mediums and spirits this was perhaps easier than it might have been for someone who was part of the community. As such I was able to separate in my mind the empirical paper which aimed to represent the narratives of mediums and the development of their identity and the literature review which used a more clinical term of ‘voice hearing’ yet still focused on distress rather than clinical diagnosis.

Summary of Literature Review

The systematic review included within this thesis followed PRISMA guidance and search five databases (Psych Info, Cumulative Index to Nursing and Allied Health Literature [CINAHL], Medline, Academic Search Ultimate, and the Allied and Complementary Medicine Database [AMED]) for quantitative studies examining the experience of voice hearing in children aged 16 and under. The literature review found 13 studies meeting the inclusion criteria and the findings of these studies were synthesised. The majority of studies looked at different factors. Some of the higher quality studies suggested the importance of traumatic life events and cognitive appraisals in the experience of distressing voice hearing, however no firm conclusions could be drawn due to small sample sizes and the variable quality of the included articles. There was also some indication of Cognitive Behavioural Therapy (CBT) strategies being useful in mitigating distress however more evidence is needed. More research taking a consistent approach needs to be conducted in this area to establish the factors that may make some children who hear voices more vulnerable to experiencing distress and how they can be supported to manage their experiences.

Points of discussion relating to Literature Review

Voice hearing

Throughout the literature review there were several points where it was necessary to make a decision over the terms used. I used the term ‘voice hearing’ where possible to capture the experience of hearing voices that others cannot (Moseley, Fernyhough, & Ellison, 2013), however many of the included studies used the term AVH (Auditory Vocal Hallucination or Auditory Verbal Hallucination) and therefore it was necessary to use this term when discussing these results. This tension between the use of ‘scientific’ or diagnostic terms within the literature I was reviewing, and my personal focus on a more inclusive and less stigmatising view of these experiences was present throughout this thesis. It has been increasingly recognised that diagnostic labels and categories can be overly simplistic and stigmatising, particularly in relation to so called ‘psychotic’ labels (Yang, Wonpat-Borjaa, Opler & Corcoran, 2010) and the Division of Clinical Psychology has guidelines on language in relation to psychiatric diagnoses (British Psychological Society, 2015) which I attempted to use throughout this research.

I had hoped that by focusing on the experience of voice hearing, with related movements towards acceptance and continuum based approaches to these experiences (Gray, 2008; Higgs, 2020), as well as, the outcomes of distress and emotional wellbeing, I might have been able to avoid adding to literature which narrowly focuses on clinical and diagnostic outcomes and measures. Unfortunately, in focusing on the topic in this way it is possible that some research or literature was missed with a vast majority of studies considering the wider terms of ‘psychosis’ or ‘psychotic like’ experiences which fit more neatly into diagnostic categories. On the other hand these categories also include experiences beyond voice hearing, which was not the focus of the review.

Age range

Another issue which came up during the literature review was the definition of ‘children’, specifically the age range this would include for a systematic literature search. I chose the age 16 and under for the review based on my experiences in the UK, with the age of 16 being when adult services would typically start. However, there are exceptions to this even within the UK. For instance, early intervention services for psychosis have historically been commissioned for 14-35 year olds (National Institute for health and Care Excellence [NICE], 2016a). Given the area of focus of this review and the links between voice hearing and psychosis it could be argued that the upper age limit be set at 14 years old, however this would have excluded a number of studies which use the definition as described above. Furthermore, whilst early intervention services may start at age 14 this does not exclude those whose first experience of voice hearing is above this age but who are legally considered children in the UK and other countries (NICE, 2016a).

Conversely, including studies which used a wider definition of childhood or who considered children and adolescents or ‘young adults’ up to the age of 21 would have expanded the number of studies which could be included and may have provided more information about factors which are related to the current emotional wellbeing of children and young people who hear voices. There is some research which suggests that people continue to develop throughout their teenage years and early twenties, with significant brain development occurring until mid-twenties (Colver, & Longwell, 2013) and so an argument could be made to include such a wide age range.

However, individuals over the age of 18 are typically grouped into the adult population within the UK. In addition, there is a large amount of research which shows that university students (typically aged 18-21) who often make up adult samples in psychology research may not reflect the general population (Hanel, & Vione, 2016). In addition, including individuals from birth to the age of 21 is arguably too broad a category with too many developmental variables for results to be meaningful.

Furthermore, longitudinal research considering the differences between individuals with and without a need for care demonstrates a difference between those who experienced hearing voices when younger than 12 and those over the age of 21 (Johns et al, 2014) and this pattern of early onset being linked to greater distress and clinical need is seen throughout the literature. This suggests that if anything an earlier definition of childhood may be more beneficial, distinguishing between those under 12 and those 13 and older.

Psychosis Research

A key finding of this review was that there is a limited amount of research into the current wellbeing of children who hear voices. Although more research has focused on the wider term ‘psychotic like’ or ‘sub clinical psychosis’ there remains a deficit in literature focusing on the experiences of young people. One reason for this may be the focus on diagnostic outcomes and models, with diagnostic categories such as ‘schizophrenia’ often being considered as being poorly defined or not applicable for children.

Interventions

Interventions for children and young people who are distressed by their experiences of hearing voices was not the focus of the literature review, however two studies which detailed pilot interventions were included. I felt that it was important to include these studies as they met the inclusion criterion of focusing on children's current emotional wellbeing and considered factors which might improve distress. Whilst there was not a lot of research in this area the key themes within these studies: building skills, distraction techniques, psychoeducation, and normalisation of experiences; are consistent with interventions for adults who may hear voices as part of 'Cognitive Behaviour Therapy for Psychosis' (CBTp; Hagen, Turkington, Berge, & Gråwe, 2011) and family interventions as recommended by NICE guidance for schizophrenia and psychosis in children and young people (2016b).

The finding that an acceptance based approach, focusing on improving wellbeing rather than symptom reduction was common to both the literature review and empirical paper. This suggests that therapies which centre normalisation, taking a non-stigmatising, validating approach, explicitly confronting feelings of shame such as Compassion Focused Therapy (CFT) and Acceptance and Commitment Therapy (ACT) may be beneficial for people who are distressed by their voices. The growth of ACT and CFT as well as mindfulness based approaches can be seen in studies looking at interventions for psychosis, with a few studies considering voice hearing specifically (Strauss, Thomas, & Hayward, 2015; Veiga-Martínez, Pérez-Álvarez, & García-Montes, 2008). There does appear to be some potential for these approaches in reducing distress for individuals who hear voices, with research showing theoretical and intervention outcomes (Dudley, Eames, Mulligan, & Fisher, 2018). However, a recent review of interventions for adults who hear voices (Thomas et al, 2014) noted that current understandings of which specific methods are useful for gaining positive outcomes for individuals who hear voices are limited and that more targeted research into which specific processes and methods are applicable for different voice hearers and service delivery contexts is needed.

Final Reflections

There were several similarities across the literature review and research paper which form this thesis. Both papers highlight the importance of normalisation and supportive environments for reducing distress for people who hear voices. The two interventions included within the literature review utilised psychoeducation for children and families as part of their intervention and found this to be effective at reducing distress; and within the research paper it was finding a supportive environment where their experiences were seen as ‘normal’ and ‘valued’ that participants began to feel comfortable with their experiences as mediums.

Additionally, both papers indicate the importance of societal views and stigma as potential factors which could increase distress for individuals who hear voices. Adult mediums reported negative perceptions from others outside of mediumistic circles which resulted in them choosing not to disclose their profession in some situations. Within the literature review there was little direct evidence of the effects of societal factors however the findings of several studies suggested that the development of further unusual beliefs (those outside of considered social norms) was related to increased distress. This suggests that the experience of voice hearing is more likely to cause distress when it is considered to be a symptom of something being wrong with the individual, for example as a sign of mental illness to be removed or seen as evidence that a child is not being truthful.

Supporting individuals to consider their experiences as part of ‘normal’ experience and helping them to understand their experiences in a validating and non-blaming way has potential for reducing distress associated with voice hearing, particularly in childhood. The adult mediums within the research paper described seeking support for their experiences which they initially found distressing and struggling with their experiences which they defined as outside of the scope of mental ill health. Focusing on distress as opposed to the presence or absence of ‘symptoms’ may be considered a more validating approach to working with individuals who hear voices.

The ACT and CFT approaches discussed within this appraisal are potential avenues through which this could be used clinically with people who present at services with distress associated with voice hearing. ACT and CFT approaches involve encouraging and demonstrating acceptance of individuals’ experiences and working with them to consider different approaches to managing these experiences. Alongside, ensuring they are able to connect with what’s important to them, while reducing any feelings of guilt or self-criticism, and is likely to improve their wellbeing without adding additional blame or stigma through trying to eliminate potentially valued experiences such as voice hearing.

Future research may wish to consider approaching this area while considering a strength based or positive approach. The participants within this research paper described benefits from engaging with their experiences and were able to use these to assist others who might be struggling. Other research has also shown that not all experiences of voice hearing is negative or causes distress. Considering what factors are related to the positive experiences of voice hearing and potential protective factors could be useful both in supporting individuals who may be experiencing distress and in reducing some potentially negative assumptions within the research base or those who engage with it.

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Doctorate in
Clinical Psychology

Lancaster
University

SECTION FOUR

ETHICS FORMS

Amy Tomlinson

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count: 5279

Thesis Research Protocol

Mental Health and Mediumship: A Narrative Analysis

Researcher:

Amy Tomlinson

Under the supervision of:

Dr Craig Murray and Dr Pete Greasley

Introduction

The proposed study is a secondary analysis of existing data; ethical permission is already in place for making anonymised transcripts from the original study available for analysis by other researchers and for conducting the proposed analysis in this application (i.e., narrative analysis) (FHM REC16001). However, irrespective of existing ethical permission it is a requirement of the applicant's course (Doctorate in Clinical Psychology programme) to submit a separate ethics application. The proposed study will form part of the applicant's thesis, the proposal for this study has been reviewed and approved by the course's programme director and thesis co-ordinator.

Literature Review

Mediums are individuals who report being able to communicate with the deceased and 'spirits'; they are consulted by a sizeable portion of the UK adult population for advice and guidance (approximately 10% in a survey by Roe, 1998). Mediums report being able to receive information from the deceased via perceptions which are not available to others; these perceptions may include being able to see (clairvoyance), hear (clairaudience), or feel (clairsentience) the presence of the deceased, as well as other 'spirits' or guides (Rock et al., 2008). Mediumship may be practised in private readings to individuals who are seeking guidance or contact with a deceased loved one, or in more public settings such as within spiritualist churches or public performances (Wooffitt, 2006).

Mediumship can be viewed as a form of dissociation (Peres, Moreira-Almeida, Caixeta, Leao & Newberg, 2012; Seligman, 2005), and there are similarities between some features of mediumistic experience and that of some people seeking treatment for mental health difficulties. For example, the medium's perceptions of communication from the deceased are often similar to the phenomenon of hearing voices seen in some clinical populations (Roxburgh & Roe, 2014; Taylor & Murray, 2012). The experience of ‘voice hearing’, termed ‘auditory hallucinations’ within diagnostic terms and often considered as a core feature of psychosis (Mawson, Cohen, & Berry, 2010), has historically been considered as a sign of poor mental health. However, a growing amount of evidence has demonstrated that experiences such as hearing voices lie within *normal* experience (Bentall, 2000; McCarty-Jones, 2012). For example, research has documented that 75% of the general population have heard a voice or seen something that other people could not (Pechey & Halligan, 2012). Furthermore, approximately 10% of the population hear voices on a regular basis and only 30% of these contact mental health services (Romme & Escher, 2000).

Although mediums have reported initially having concerns about their mental health when their abilities first developed (Roxburgh & Roe, 2014), there is no evidence to suggest that mental health difficulties *underpin or give rise* to mediumistic abilities. While there is a high prevalence of traumatic life events among mediums (Andrew et al, 2008), the evidence suggests they have positive psychological health and well-being (Moreira-Almeida et al, 2008). However, there is potential for difficulties *surrounding the work* of a medium to be detrimental to their mental health in the long-term. For example, mediums have reported feeling spirits’ ailments and causes of death as part of their clairsentience experiences (Rock et al., 2008; Roxburgh & Roe, 2014). Furthermore, in working with individuals who are bereaved they may be exposed to their distress (Newell, Nelson-Gardell, & MacNeil, 2016), yet do not have formal training to respond to such individuals or process the impact of such exposure on themselves. Therefore, there is a potential for mediums to experience difficulties in relation to their mental health as a result of their mediumistic work (Roxburgh & Roe, 2014). In addition, given the widespread scepticism towards mediums (Wiseman & O’Keeffe, 2005), they may be less likely to seek formal help with such difficulties. Despite these observations, there is a paucity of research specifically on psychological difficulties experienced by mediums, both surrounding and during the course of their mediumistic work.

Understanding these experiences has the potential to identify how mediums maintain good psychological health as well as how services may engage with them during times that they experience particular difficulties.

Qualitative research has already proven useful in aiding an understanding of the experience of mediumship, exploring how mediums interpret and make sense of their abilities and their perceptions of their role as a helping professional (Osborne & Bacon, 2015; Roxburgh & Roe, 2013). Taylor and Murray (2012) explored the phenomenology and meaning of the experience of clairaudience amongst mediums and their findings suggested that how an individual appraises the event can contribute to their level of distress. Through selecting and engaging with positive voices, setting limits on contact with voices, and accepting the voices through a 'frame of reference' (mediumship and abilities), more meaningful experiences and more positive outcomes for participants were reported. Roxburgh and Roe (2014) conducted an initial investigation into how mediums understood their experiences and how they attributed them to mediumistic abilities. Using a phenomenological analysis of interviews with 10 spiritualist mediums they found most participants linked the onset of mediumship to spontaneous anomalous experiences such as hearing voices, experiencing unusual physical sensations, and 'visions', that often occurred in childhood. These experiences were then interpreted as signalling sensitivity to mediumistic phenomena, often within the context of a normalising and validating family environment.

The use of interpretative phenomenological analysis (IPA), such as in the studies discussed above (Osborne & Bacon, 2015; Taylor & Murray, 2012; Roxburgh & Roe, 2014), allows researchers to explore phenomena from an 'insider perspective' (Conrad, 1987). Phenomenological studies seek to understand participants' internal worlds to interpret their cognitions, understandings and the meanings, valuing the participants' perspective and expertise of their own experiences (Smith, 1996). Whilst IPA is suited to exploring participants' understandings of their internal worlds, self, and identity, uncritically focusing upon such perspectives can sometimes overlook social and structural factors which influence personal individual experiences (Crossley, 2000). Considering the wider context of mediums' experiences is particularly important as previous studies have highlighted the role of social and family environment as well as participants' frame of reference in accepting and understanding their experiences as mediumistic (Osborne & Bacon, 2015; Taylor & Murray, 2012; Roxburgh & Roe, 2014).

One approach which considers the wider societal contexts and constructs which shape identity is Narrative Analysis. McAdams (1985) argues that narrative is at the core of self-definition, and further, that identity is a life story. Within a narrative approach events and occurrences are taken to be experientially configured into a temporal whole with a beginning, middle and end, with a person's experiences of the present reciprocally informing their understanding of their past and future. Narrative analysis allows researchers to observe this meaning-making process. Furthermore, as the stories that we tell are connected to and limited by wider stories which reveal culturally shared meanings and expectations, narrative analysis can also disclose how the social context contributes to individuals making sense of their experiences (McMahon et al. 2012). Narrative analysis using a temporal structure would therefore be useful for understanding traumas which may precede psychic/mediumistic abilities, the development of these experiences and how they are subsequently adjusted to and/or coped with.

Understanding the beliefs and experiences of mediums regarding their mental health difficulties is important in the same way as it might be for minority and religious groups. The sense-making and experiences of these groups might differ from that of broader populations. Just as religious and/or cultural frames of reference might mediate mental health experiences, or provide an interpretive lens for anomalous experience, so too might mediumistic understandings and frames of reference (Taylor & Murray, 2012). These understandings could help inform mental health professionals with regards to how to respond appropriately to and help mediums who seek help for mental health difficulties (such as trauma) without trying to change valued aspects of such experiences (such as their communications with the dead). Such understandings may also be beneficial for clinicians working with other individuals without mediumistic abilities but who report similar experiences (such as voice hearing). For example, understanding how mediums may live well with their experiences (as well as when they might need and seek help) could help inform interventions for individuals who do not.

The primary aim of this study therefore is to understand mental health experiences for mediums and to identify how health professionals might work with such clients when seeking help without assuming that the mediumistic work and abilities are problematic. A secondary aim is to consider how individuals might live well with anomalous experiences that others might find distressing in order to inform interventions for those who are distressed.

Method

Design

The proposed study is a secondary analysis of existing data; ethical permission is already in place for making anonymised transcripts from the original study available for analysis by other researchers and for using the proposed method of analysis (narrative analysis) (FHM REC16001). The study will use qualitative methodology analysing the existing data using narrative analysis. Narrative analysis is often used to investigate healthcare and rehabilitation, particularly when the focus of research interest is long-term. Within a narrative approach, events and occurrences are taken to be experientially configured into a temporal whole with a beginning, middle and end, with a person's experiences of the present reciprocally informing their understanding of their past and future. This makes narrative approaches particularly suited for the study of accounts of mental health over an extended period of time. A narrative analysis of the existing data using a temporal structure is useful for understanding traumas that may precede psychic/mediumistic abilities, the development of these experiences and how they are subsequently adjusted to / coped with.

The Data Set

A narrative analysis will be conducted on an existing data set derived from a qualitative, methodological pluralistic project conducted by one of the applicant's thesis supervisors (in which the same data set is analysed using different qualitative approaches). The data set consists of transcripts derived from interviews with 14 participants (one male; 13 female; mean age of the sample was 46, range 25 to 63 years). All participants reported psychic or mediumistic experiences from when they were children. Participants had been practicing as a psychic professional for a mean length of 12.4 years (range 2-28 years) at the time of data collection. Participants were not undergoing or seeking any form of treatment for mental health difficulties or related issues, nor had they undergone such treatment in the previous 2 years.

The data set was collected via semi-structured one-to-one interviews (5 face-to-face, 4 via telephone, 5 using video-call). The interviews covered several areas including (1) introductory questions looking at mediumistic abilities, time spent practising as a medium, and establishing how and when they used their clairaudience/voyance/sentience in practice (2) questions exploring the phenomenology of participants experiences, including what it is like to be clairaudience/voyance/sentient and (3) questions exploring their well-being, and the well-being of the clients.

Proposed study focus

From the available data set the proposed study will be focusing on transcripts which will allow for extracting data relating to the participants' understanding of their mental health and the development of anomalous / mediumistic experiences over time. The proposed study will be focusing on the participants' narrative and the development of mediumship as an identity and reference frame for anomalous experiences.

Proposed Analysis

A narrative analysis will be used to analyse the data in order to produce a composite story of the development of anomalous and mediumistic ability over mediums' life span. The analysis will be conducted based upon key principles of narrative analysis using guidelines proposed by Fraser (2004) and Andrews, Squire, and Tamboukou (2008). The key steps in the analysis are:

1. Initial read of transcripts to familiarise the researcher with the data, noting initial observations.
2. Transcripts are re-read several times in order to produce a summary story for each participant. These stories summarise key events and characters, in addition to noting significant thoughts and emotions associated with the different stages of participants' experience.
3. Individual accounts are synthesised together through a process of comparison between stories, merging areas of commonality, and incorporation of elements of each participant's story that illuminate or extend that of other participants.

Ethical Issues

Obtaining Ethical Approval

University Ethical approval is sought for the use of the data in a separate narrative analysis study. Although there is existing ethical approval to use the target data set in the manner outlined in this proposal, a full ethics proposal is being submitted for FHMRES consideration as this is a course requirement for the applicant on the DClinPsy programme. This study does not access NHS staff or patients and therefore only requires FHMREC approval.

Data Management Plan

Access to and use of participant transcripts will be in accordance to the original approvals given regarding data management for the originally approved study (ethics ref: FHM REC16001). Upon approval of this application, transcripts will be made available to the applicant by the academic supervisor (Craig Murray). All transcripts will be password protected and stored electronically on a secure drive (Lancaster University VPN). The supervisor will make anonymised transcripts available via ‘Box for Lancaster University’. Passwords for each transcript will be provided in separate emails from those with Box links. The applicant’s access to these transcripts will cease once the thesis component of the DClinPsy has been successfully met. The applicant will not have access to participants personal/identifying details. Data excerpts will be used in the thesis and in publications arising from the research.

Timescale

The project will commence, following the receipt of ethical approval from the FHMREC. The project will end with the submission of the assignment to Lancaster University.

Dissemination Strategy

A full report will be written and may be submitted to an academic journal. A presentation will be given at Lancaster University to staff in the Faculty of Health and Science Department and trainee clinical psychologists. The presentation will be made available via the University's website.

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Ethical proposal Forms.

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Title of Project: Mental health and mediumship: A Narrative Analysis

Name of applicant/researcher: Amy Tomlinson

ACP ID number (if applicable)*:

Funding source (if applicable)

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☒ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☐ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist, a student on the Clinical Psychology Doctorate programme, part of the Division of health research

2. Contact information for applicant:

E-mail: a.tomlinson@lancaster.ac.uk **Telephone**: 07704366260 (please give a number on which you can be contacted at short notice)

Address: 15 Quarry Mount Mews, Quarry Road, Lancaster, LA1 3BZ

3. **Names and appointments of all members of the research team (including degree where applicable)**

Amy Tomlinson, Trainee Clincial Psychologist student on the DClinPsy programme (BSc Psychology, MSc Rehabilitation Psychology)

Dr Craig Murray, Senior Lecturer (BA Psychology, MSc Health Psychology, PhD and D.Health.Psy)

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Dr Craig Murray and Dr Pete Greasley

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**: Senior Lecturer, Lancaster University and Teaching fellow, Lancaster University

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: 06/19 End date: 11/19

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

The primary aim for the study is to explore mediums' understanding of the development of their mediumistic experiences and identity over time and to consider how these might effect their mental health. Mediums are individuals who report experiencing the voices, feelings, and visions of the deceased. Data from interviews with 14 mediums will be analysed. This data has already been gathered as part of a previous study conducted by one of the project supervisors. Consent and ethical approval was given at the time of that study for the data to be used in future studies. Data will be analysed using a narrative approach to consider how unusual experiences develop over time and how these experiences come to be seen as mediumistic abilities. Narrative approaches consider the development of events and experiences such as illness over time; organising these experiences into a coherent story with a beginning middle and end.

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

Interview transcripts from a study conducted by project supervisor Craig Murray. The existing data set consists of 14 participants (one male; 13 female), mean age of the sample was 46 (25 to 63 years). The data is derived from a qualitative, pluralistic project (in which the same data set is analysed using different qualitative approaches) conducted by one of the applicant's thesis supervisors. All participants reported psychic or mediumistic experiences from when they were children. Participants had been practicing as a psychic professional for a mean length of 12.4 years (range 2-28 years). Consent was gained via participants, and through ethical approval, to use the data collected in these interviews for analysis in future research. Data is transcripts of 14 interviews with psychics/mediums collected as part of a study into the mental health of mediums.

4a. How will any data or records be obtained?
Data is currently held by project supervisor as part of a prior study.

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' n o

4c. If yes, where relevant has permission / agreement been secured from the website moderator? n o

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? n o

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

All documents will be password protected and all data stored electronically on a secure drive (Lancaster University VPN). At the end of the study, the anonymised transcripts will be transferred electronically to the DClinPsy Research Coordinator using a secure method supported by the University. They will be instructed with a date of when to delete the anonymised transcripts. These transcripts will be stored for 10 years before being deleted. No personal or identifying information will be accessed as part of this project.

6a. Is the secondary data you will be using in the public domain? n o

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

The data is derived from a qualitative, pluralistic project conducted by one of the applicant's thesis supervisors (in which the same data set is analysed using different qualitative approaches). Data is transcripts of 14 interviews with psychics/mediums collected as part of a study into the mental health of mediums. Consent was gained via participants, and through ethical approval, to use the data collected in these interviews for analysis in future research.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Data will not be shared until the applicant has published the results of the study. After that time data will be shared on request with genuine researchers on a case-by-case basis by the applicant and supervisor.

7b. Are there any restrictions on sharing your data?

As the sample size is relatively small and participants were recruited from a specialist profession through local advertisements even after full anonymization there is a small risk that participants can be identified. Therefore, data will be shared on request with genuine researchers on a case-by-case basis by the applicant and supervisor.

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained? The applicant will not have direct access to participants who provided the origional data and will not have access to their contact details. All data will be annonymised prior to analysis.

9. What are the plans for dissemination of findings from the research?

The applicant and research supervisors will see the data generated from this research. The findings will be disseminated as part of the applicants Doctoral thesis and through a research presentation to university staff and other students as part of the thesis process. Results of the research may be submitted for publication in an academic/professional journal.

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

n/a

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

2. **Anticipated project dates (month and year only**)

Start date: End date

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

8b. Are there any restrictions on sharing your data ?

9. Consent
a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? N/A

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

SECTION FOUR: signature

Applicant electronic signature: A. Tomlinson Date 13/05/19

Student applicants: please tick to confirm that you have discussed this application with your supervisor, and that they are happy for the application to proceed to ethical review ☐

Project Supervisor name (if applicable): ☐ Date application discussed ☐

Submission Guidance

1. **Submit your FHMREC application by email to Diane Hopkins (**d.hopkins@lancaster.ac.uk) as two separate documents:
    - i. **FHMREC application form.**
      Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    - ii. **Supporting materials.**
      Collate the **following materials for your study, if relevant, into a single word document:**
        - a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
        - b. Advertising materials (posters, e-mails)
        - c. Letters/emails of invitation to participate
        - d. Participant information sheets
        - e. Consent forms
        - f. Questionnaires, surveys, demographic sheets
        - g. Interview schedules, interview question guides, focus group scripts
        - h. Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
    - i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to **Diane Hopkins by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
    a. existing documents/data only;
    b. the evaluation of an existing project with no direct contact with human participants;
    c. service evaluations.

3. **<u>You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application</u>**

SECTION FIVE

APPENDICES

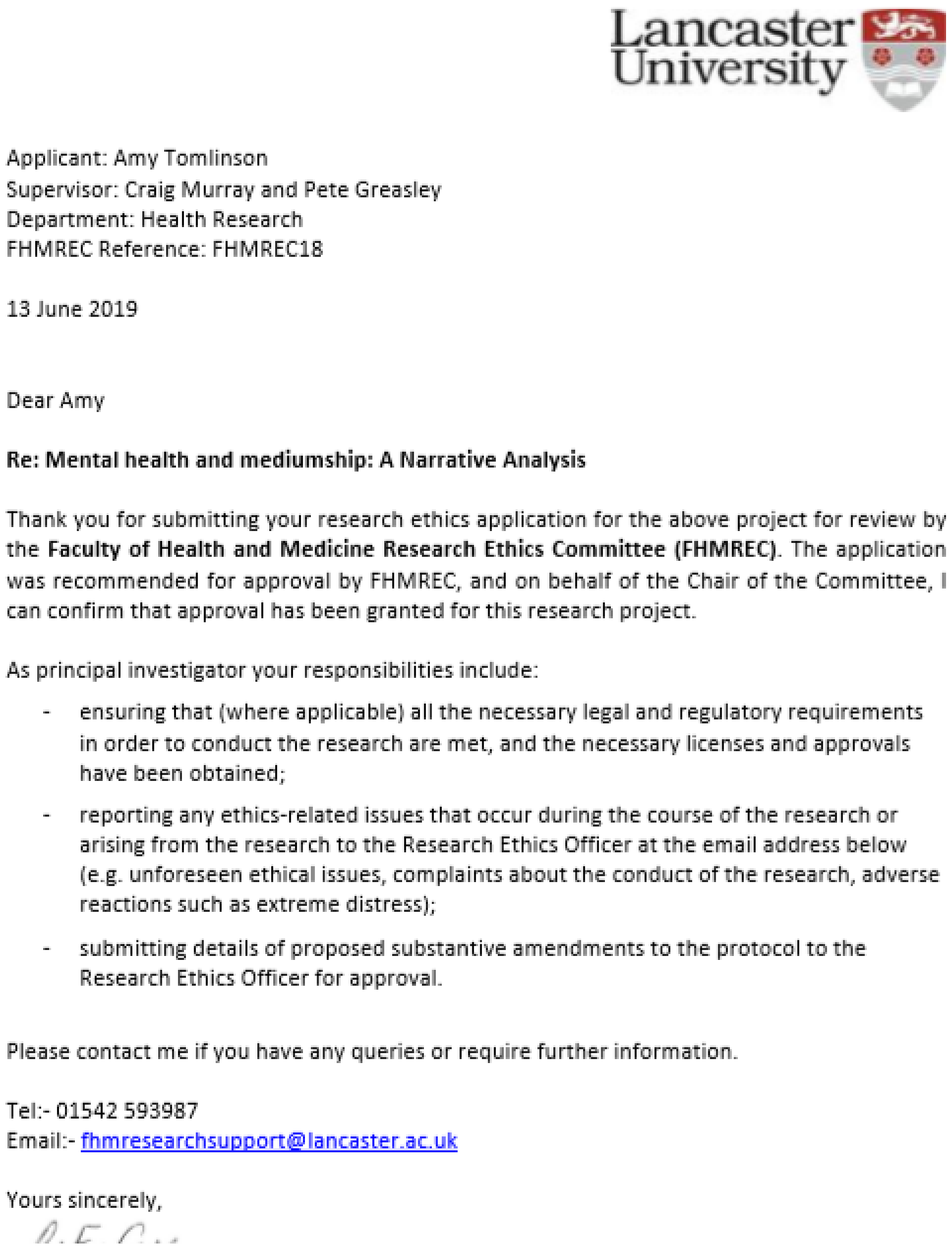
Amy Tomlinson

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Appendix A

Ethical Approval



Lancaster University

Applicant: Amy Tomlinson
Supervisor: Craig Murray and Pete Greasley
Department: Health Research
FHMREC Reference: FHMREC18

13 June 2019

Dear Amy

Re: Mental health and mediumship: A Narrative Analysis

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,