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Table of Contents

Table of Tables....4

Table of Figures....6

Abstracts....7

Systematic Review of the Literature: The Process and Impact of Disclosure of Suicidality and Self-Harm on Social Media....12

- Abstract....13
- Introduction....15
- Method....18
- Results....28
- Discussion....51
- Conclusions....62
- References....64

Service Improvement Project: Understanding Neurodivergent Clients' Experience of the DBT Pathway within the Buckinghamshire Psychological Therapies Team….73

- Abstract....75
- Introduction....76
- Method....78
- Results....83
- Discussion....98
- References....103

Theory Driven Research Project: Social Identity, Identity Integration, and Wellbeing in Voice Hearers: An Experimental Investigation....108

- Abstract....109
- Introduction....111
- Method....114
- Results....120
- Discussion....131
- References....136

Executive Summary....142

Connecting Narrative....144

Acknowledgements....147

Appendices....149

- SRL Appendix A: Full database search terms and number of results....149

SRL Appendix B: Archives of Suicide Research Journal Submission Guidelines 152
SIP Appendix A: Practitioner Points.....159
SIP Appendix B: Adapted versus non-adapted group differences.....160
SIP Appendix C: Standards for Reporting Qualitative Research guidelines.....162
SIP Appendix D: Service User Semi-Structured Interview Schedule.....164
SIP Appendix E: Easy-Read and Full Information Sheet, Communications Preferences Questionnaire, and Consent Form.....166
SIP Appendix F: Staff Survey Questions.....173
SIP Appendix G: Coding Process Examples.....175
SIP Appendix H: Additional service user illustrative quotes.....178
SIP Appendix I: Additional Staff Illustrative Quotes.....181
SIP Appendix J: Psychology and Psychotherapy: Theory Research and Practice Journal Submission Guidelines.....185
TDRP Appendix A: Practitioner Points.....203
TDRP Appendix B: Script and YouTube link for Intervention video.....204
TDRP Appendix C: Research Poster and Participant Sources.....208
TDRP Appendix D: Debrief.....210
TDRP Appendix E: Ethical Approval Letter CUREC.....212
TDRP Appendix F: Measures.....213
TDRP Appendix G: Additional Demographic Information.....217
TDRP Appendix H: Residual Plots.....222
TDRP Appendix I: Journal Submission Guidelines.....228

Table of Tables

Table 1 *Quality Appraisal of Studies using MMAT*.....24

Table 2 *Data Extraction*.....28
Table 1 *Interviewed service user demographic characteristics*.....81
Table 2 *Attendance and drop-out rates for groups*.....91
Table 3 *Baseline Outcome Measures*……..95
Table 4 *Outcome measures pre- and post- group*……..97
Table 1 *Measures*.....111
Table 2 *Participant demographic characteristics*.....114
Table 3 *Baseline descriptive measures between experimental groups*.....115
Table 4 *Pre- and post-video state measures*.....116
Table 5 *Direction of Individual Integration Score Change*.....119

Table of Figures

Figure 1 *PRISMA flowchart*.....21
Figure 2 *Conceptual map of findings*.....41
Figure 1 *Number of interviewed participants by stage of DBT pathway*.....82
Figure 2 *Service user perspective on experience of BPT*.....82
Figure 3 *Staff perspective on service user experience of BPT*.....88
Figure 1 *Social identity integration change, pre- and post-intervention across groups*
.....117
Figure 2 *Individual State Integration Change Scores*.....118
Figure 3 *Individual Identity Change Scores*.....122

Abstracts

Systematic Review of the Literature: The Process and Impact of Disclosure of Suicidality and Self-Harm on Social Media

Introduction: Suicide and self-harm pose significant youth risks. Some youths use social media to disclose suicidality and self-harm, though associated risks and benefits remain unclear. This review aimed to explore the process and impact for youths of disclosure of suicidality and self-harm on social media.

Method: Four databases were systematically searched, with results screened against predefined criteria, yielding 33 studies. A narrative synthesis was employed due to expected heterogeneity of study aims and methods, with data extraction and quality critically appraised.

Results: The review identified diverse motivations for disclosure, which shaped the content shared. Key motivations included seeking support and attention, expressing self, connection, and reducing urges. Disclosure form and explicitness varied, including graphic imagery, vague expressions of distress, and livestreams. Findings consistently highlighted a ‘double-edged sword’ effect of disclosure on social media, offering both potential for support and risk of harm. Highly moderated platforms were less frequently associated with negative outcomes; harmful responses ranged from no response to suicide incitement. Gender differences were noted, with a consistent female predominance in self-harm studies, compared with male overrepresentation in live-broadcast suicides. Tentative evidence supporting proactive outreach interventions was also found.

Conclusions: Results suggest social media is both a vital source of support and a potential source of harm for youths disclosing suicidality and self-harm, with outcomes influenced by individual characteristics, platform, and audience responses. Policy efforts are needed to reduce harm, yet blanket bans risk eliminating crucial support functions. Future research should focus on longitudinal, larger-scale studies, and in-depth understanding of individual experiences, while navigating ethical challenges.

Keywords: Suicide, self-harm, social media, disclosure

Service Improvement Project: Understanding Neurodivergent Clients' Experience of the DBT Pathway within the Buckinghamshire Psychological Therapies Team

Objectives: This Service Improvement Project aimed to understand the experience of neurodivergent individuals in accessing Dialectical Behaviour Therapy (DBT) within Buckinghamshire Psychological Therapies service, including barriers and facilitators to this, and to make recommendations for change.

Method: A mixed-method approach was used. Semi-structured interviews were conducted with 10 neurodivergent DBT service users to explore their experience with the service; online qualitative surveys were completed by 11 staff. Thematic analysis was used to explore service user and staff experiences. Forty-two service users' group clinical data were analysed using descriptive statistics.

Results: For the service users, themes of 'I feel different', 'we are different', and 'being different within the mental health system: wider system helps and hinders agency' emerged. For staff, themes of 'uncertainty of diagnosis', 'staff are willing but constrained', and 'importance of a paced, flexible approach' arose. Notable dropout rates were found across DBT-informed groups for neurodivergent service users Clinical data confirmed that neurodivergent service users are more likely than neurotypicals to drop out of the DBT-informed group, even an adapted group.

Conclusions: Needs should be sensitively explored, and adaptations should be personalised. Qualitative findings support the continued use of the adapted group.

Keywords: neurodivergence, autism, ADHD, Dialectical Behaviour Therapy, service access

Social Identity, Identity Integration, and Wellbeing in Voice Hearers: An Experimental Investigation

Background: Integrating a voice hearer identity with other important social identities to form a positive, coherent sense of self is associated with better wellbeing for people who hear voices. There are increasing lived experience narratives shared online in video format about the voice hearing experience, though it is unclear whether videos like this foster increased social identity integration for viewers.

Method: In this study, we compared the impact of watching lived experience stories featuring the integration of a voice hearer social identity, with a control video, on variables of identification, identity integration, and wellbeing.

Ninety-four people who self-identified as hearing voices completed an online survey, completing baseline and state measures including social identity, identity integration, and wellbeing. Participants were then randomised to watch one of two videos, (a) a co-produced, 8-minute video-based intervention, featuring three actors describing their experience of integrating their voice hearer identity into their wider sense of self, or (b) a control video about the weather. Participants completed post-intervention measurements of state social identity, identity integration, and wellbeing. ANOVAs and linear regression were used to analyse data.

Results: There was no significant effect of the lived-experience narrative video on voice hearer identity integration, nor was identity integration found to predict change in wellbeing or post-intervention wellbeing scores. However exploratory analyses showed a significant group by time interaction for identity, suggesting that identification as a voice hearer may have been enhanced by the video intervention.

Conclusions: The lack of significant findings regarding identity integration may reflect the brief nature of the intervention, or the complexity of social identity integration processes among voice hearers. Further exploration of identity-related mechanisms in voice hearers is warranted; future research could consider more intensive interventions and explore individual differences.

Keywords: Hearing Voices, Social Identity, Identity Integration

Systematic Review of the Literature: The Process and Impact of Disclosure of Suicidality and Self-Harm on Social Media

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Doctorate in Clinical Psychology

Word Count: 7000

Proposed Journal: Archives of Suicide Research. This is chosen as it is an international journal in the field of suicidology. Journal submission guidelines can be found in Appendix B.

Abstract

Introduction: Suicide and self-harm pose significant youth risks. Some youths use social media to disclose suicidality and self-harm, though associated risks and benefits remain unclear. This review aimed to explore the process and impact for youths of disclosure of suicidality and self-harm on social media.

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support functions. Future research should focus on longitudinal, larger-scale studies, and in-depth understanding of individual experiences, while navigating ethical challenges.

Keywords: Suicide, self-harm, social media, disclosure

Introduction

Understanding suicide prevention and risk is vital. Suicide causes 720,000 deaths each year globally, being the third leading cause of death for 15–29-year-olds (World Health Organisation, 2025). Further, self-harm, defined as deliberate, direct damage to one's body, is associated with increased risk of suicide alongside other psychological and physical risks (NICE, 2025). Given these risks, it is imperative to understand factors influencing suicidality and self-harm.

A range of definitions exist for social media (SM), arising quickly given its rapidly evolving nature (Aichner et al., 2021). This systematic review uses the most commonly cited definition within Aichner et al.'s (2021) review: SM is "a group of Internet-based applications that builds on the ideological and technological foundations of Web 2.0, and that allows the creation and exchange of user-generated content" (Kaplan & Haenlein, 2010, p. 61). SM use has been increasing amongst youths since its late 1990s inception, to near-ubiquity (Abi-Jaoude et al., 2020; Yang et al., 2021).

Research has found positive and negative aspects of SM use. Benefits include building communities, providing support, allowing for self-expression, and strengthening relationships; conversely use has been linked to loneliness, addiction, bullying, and depression (Sadagheyani & Tatari, 2021). The UK government has warned of SM's risk to mental health (Department of Health and Social Care, 2018). The Werther effect describes imitation suicides linked to observing suicide content in the media (Niederkrotenthaler & Till, 2020). Extrapolated to SM, official guidelines exist about discussing suicide on SM in a safe, effective way, such as not sharing explicit methods (Engelson et al., 2023). Nonetheless, there are also constructive,

preventative functions of user-generated suicide content (Eichenberg & Schott, 2017).

Theoretical underpinning

While suicide and self-harm research has often focused on an individual level, there is increasing focus on the socioecological context within which these behaviours occur (Standley, 2020). Intersecting social identities and social interactions create risk and protective factors (Standley, 2020). Durkheim (1951) theorised that increased integration gives individual group members purpose and meaning. The idea of perceived belongingness was built upon by Joiner (2005) in the Interpersonal Theory of Suicide. This identified the convergence of perceived burdensomeness and thwarted belongingness as leading to suicidal thoughts, with acquired capability for suicide developed through repeated exposure and habituation to painful and provocative events. SM can offer a space to build and strengthen connections and sense of belonging which may lead to the building of online support systems. Given its potential benefits, combined with the aforementioned risk, a better understanding of disclosure process and impact may shed light on when, how, and for whom disclosure helps and harms.

The Disclosure Processes Model (Chaudoir & Fisher, 2010) conceptualises how and why people disclose concealable stigmatised identities. This model posits that disclosure of these identities can have varied effects, depending on goals, content, and reaction. Goals include both approach goals (gaining social support, reducing psychological burden, and education) and avoidance goals (avoiding negative outcomes such as rejection or further stigmatisation). Content refers to what is being disclosed: the depth, breath, duration, and emotional content of the information

shared about the stigmatised identity. Various reactions can be experienced, affecting disclosure impact, ranging from supportive and accepting, to rejecting and discriminatory. Processes such as alleviation of inhibition, social support, and changes in social behaviour mediate health outcomes (Chaudoir & Fisher, 2010). Nuance may exist between those disclosing past versus current suicidal ideation or behaviour, given possible differing goals and reactions (Sheehan et al., 2019). Varying levels of disclosure exist: Corrigan and Rao (2012) highlight stages including avoidance, secrecy, selective disclosure, indiscriminant disclosure where no efforts are made to hide mental ill health, and broadcasting to educate others. These stages are particularly relevant on SM, where different platforms may encourage varying levels of openness, and individual choices like posting anonymously further influence disclosure.

Review Rationale

Several reviews summarise the use of SM in relation to suicidality and self-harm (Biernesser, 2019; Dodemaide et al., 2019; Marchant et al., 2021). These reviews highlighted the dual nature of SM's impact on self-harm and suicidality, with negatives including cyberbullying, overuse, and exposure to distressing content, and benefits including information and social support. Biernesser (2019) and Dodemaide et al. (2019) both recommended investigation of protective factors associated with sharing self-harm content online. Susi et al. (2023) found a predominantly harmful impact of viewing self-harm images on SM, though disclosing one's own self-harm may be different to simply viewing others' disclosures. Davies et al. (2024) specifically examined disclosure of suicidal thoughts and behaviours by young people, typically in-person or via technology. They recommended further exploration of mechanisms of disclosure, given the largely cross-sectional papers included.

Building on these findings and recommendations, this review will be, to the author's knowledge, the first to focus specifically on disclosure of suicidality and self-harm on SM by youth.

This review will address the following research questions:

- What is the process of disclosing suicidality and self-harm on SM?
- What is the impact of disclosing suicidality and self-harm on SM?

Method

A systematic review, following PRISMA guidelines (Page et al., 2021), was conducted using narrative synthesis as described by Popay et al. (2006). The study was pre-registered on PROSPERO (CRD420250510512; registration date 26 May 2025).

Search Strategy

A search strategy was developed (see Appendix A) including key concepts of suicidality/self-harm, SM, and youths. Disclosure was not included as a direct search term, a decision made as many relevant articles do not explicitly name 'disclosure' or adjacent terms (e.g. posting, tweeting), instead describing general engagement with 'online communities' where disclosure implicitly occurs. By not narrowing the search term with this specific variable, we aimed to include all pertinent papers addressing the various ways disclosure happens. A systematic search was completed on PsycInfo, PubMed, Scopus, and Web of Science. Backwards reference searching and forward citation searching was performed on all full texts; no new studies were added.

Inclusion Criteria

Studies were included if they were:

- Focused on a youth population, using the United Nations definition of 15-24-years-old (United Nations, 1981), where mean age, and the majority of participants fell within, or were estimated to fall, within this range.
- Studies of anonymous content, only if age ascertainment methods (e.g. content review) were present, and age was estimated to be within 15-24-years-old.
- Primarily focused on the process and/or impact of disclosure of suicidality and/or self-harm on SM. Disclosure typically focused on the creation of content and posting/sharing.
- Published since 2009; while SM and its use has changed over time, given the novelty of this review a broad date range was selected. 2009 was chosen as a turning point from static profiles to real-time socially validated environments, with the launch of the Facebook ‘like’ button and the use of the real-time web (MacManus, 2024), allowing for better exploration of interactions.

Exclusion Criteria

Studies were excluded if they were:

- Focused on harmful eating disordered behaviour, given distinct differences in these content types (Mavandadi & Lewis, 2021).
- Gaming platforms featuring an element of socialising, as socialising is not typically primary focus.
- Not focused primarily on disclosure, such as papers simply concerned with accessing or using SM.

- Book chapters.
- Focused on ‘digital self-harm’, also known as self-cyberbullying.
- Focused on children under 15, or only adults, or where the majority fell outside of 15-24-years-old. Anonymous studies where age was not mentioned were also excluded.
- Not in the English language.
- Non-peer reviewed papers.
- Non-empirical papers.

Epistemology of papers

This review chose to include quantitative, qualitative, and mixed-methods studies. This decision was driven by the research questions, which sought to understand both the process and the impact of online disclosure. To gain a holistic understanding, it was necessary to draw on a range of forms of evidence.

The rationale for including qualitative studies was to provide rich, contextualised insights into the lived experience, motivations, and subjective meanings of disclosure for individuals. Quantitative studies, in contrast, offered valuable data on the prevalence of certain behaviours, correlations between variables, and the outcomes of experimental interventions. Combining these different perspectives provides a more complete, nuanced picture than either methodology could alone.

Synthesising these different study types, however, requires acknowledging their distinct epistemological foundations. The quantitative studies were largely rooted in a post-positivist paradigm, which assumes an objective reality that can be measured and tested to identify patterns and potential causal relationships. In contrast, the qualitative studies were typically grounded in an interpretive or constructivist

paradigm. This views knowledge as subjective, context-dependent, and co-constructed between individuals (including the researchers), seeking to understand personal meaning rather than objective truth.

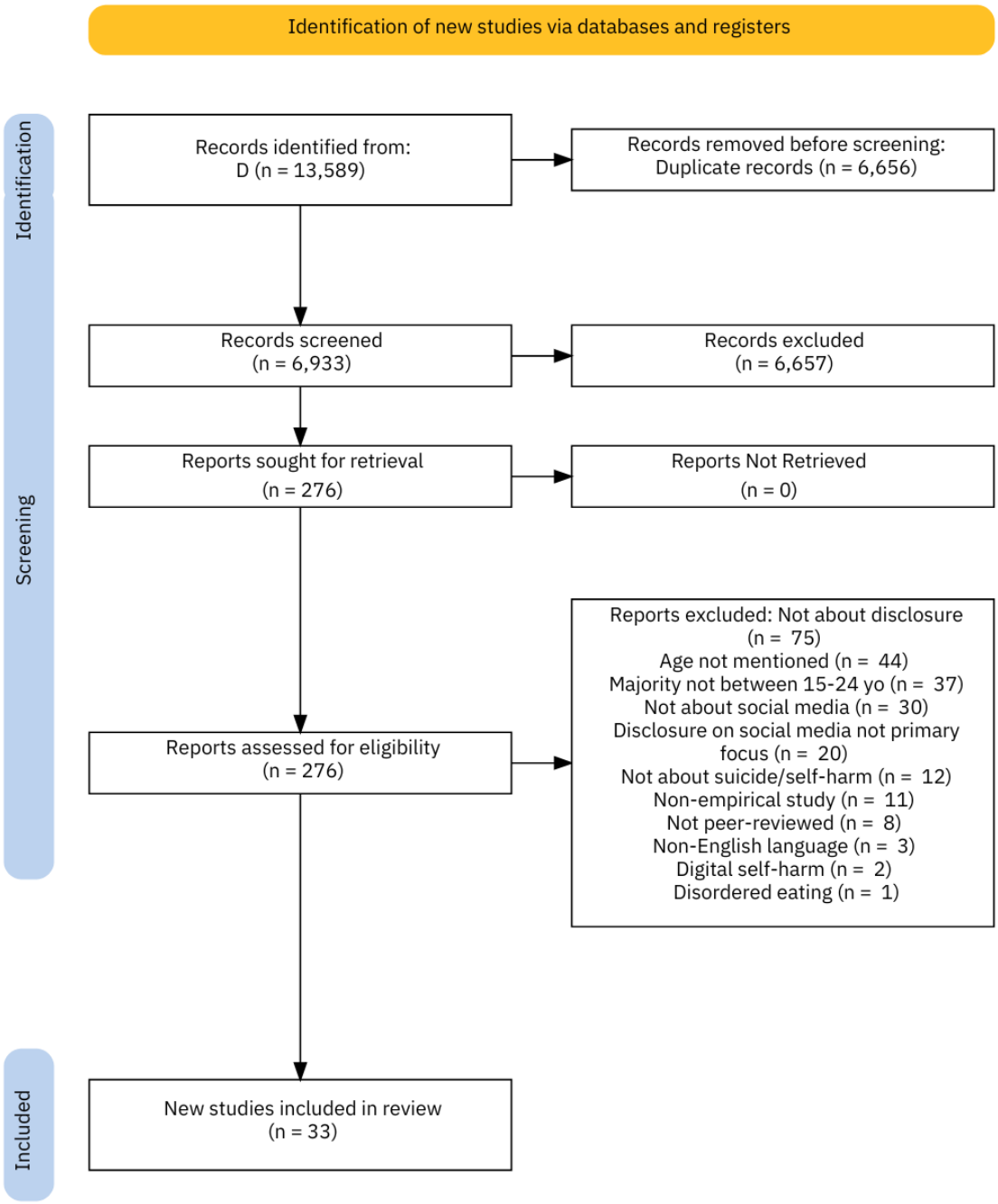
The primary issue this raises is the challenge of integrating findings that may be based on different assumptions about what constitutes ‘knowledge’. This review does not attempt to resolve these epistemological differences or to privilege one form of knowledge over the other. The narrative synthesis approach was chosen as it allows these different types of evidence to be placed in dialogue. The goal was not to find a single, objective ‘truth’, but to use the rich, interpretive findings from the qualitative literature to add depth, context, and explanatory power to the patterns and observations identified in the quantitative literature. This approach embraces the complexity of the topic, providing a multi-faceted understanding rather than a single, simplified answer.

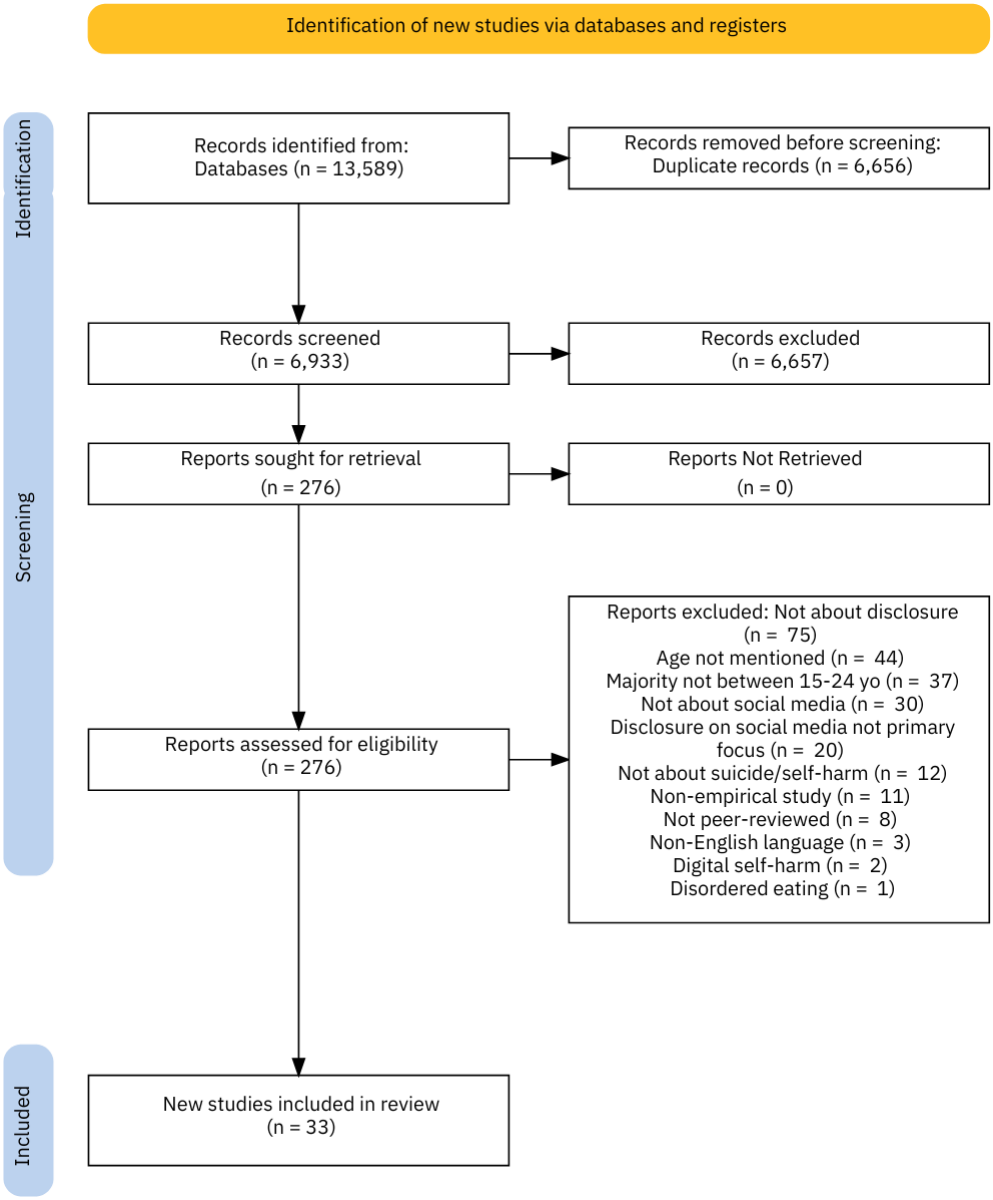
Study Identification

13,589 studies were identified. After de-duplication, RQ screened 6,933 titles/abstracts. A second reviewer screened 20% of these abstracts, with a Cohen’s kappa (κ) of 0.95 reached. Differences in ratings were discussed and resolved. The second reviewer also screened 25% of the full texts, with a Cohen’s kappa (κ) of 0.91 reached, before disagreements were resolved. Rating disagreements were resolved by both reviewers, supervised by MK, with consensus established in regular meetings. The process of study identification is shown in PRISMA flowchart (Figure 1).

Figure 1

PRISMA flowchart





Quality Appraisal

Given heterogeneity of papers, study quality appraisal used the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018), as it allowed both qualitative and quantitative screening.

CE co-rated 30% of the texts, with discrepancies discussed. The papers were of varied quality (Table 1). Notwithstanding the case studies, the qualitative studies tended to be good quality. A recurring theme, particularly for qualitative and

quantitative descriptive studies, was limited generalisability with studies often using publicly available self-selecting samples from niche platforms or subcommunities. All papers were included, with consideration of quality maintained.

Conceptual Mapping

The overall review used a narrative synthesis approach. Within the protocol delineated by Popay et al. (2006), one possible model suggested for exploring relationships is the process of conceptual mapping. The map was created using a relational approach as described by (Conceição et al., 2017). This method uses graphical representations to show relationships between concepts, with connecting lines and arrows indicating the nature of those connections. This approach had strengths in identifying themes and interconnectedness among concepts (Conceição et al., 2017). To ensure this process was systematic and replicable, the following protocol was used to develop the conceptual map. The first stage was concept identification, involving identifying key concepts, themes, and findings. Next, thematic grouping was done, iteratively grouping clusters based on conceptual similarity, for example all concepts related to motivation were grouped. Following this, thematic clusters were visually mapped and linked, with lines and arrows drawn between concepts that were described in the literature. The final step was iterative refinement, with the map undergoing multiple revisions, using supervision to refine this and checking of the map and direction of the relationships to ensure faithful representation of the evidence synthesised in the review. By following this

protocol, the conceptual map served as an analytical tool for synthesising the heterogeneous findings into a coherent, replicable framework.

Table 1

Quality Appraisal of Studies using MMAT

MMAT - Qualitative								
Main Author(s)	Screen: Clear research questions?	Screen: Data collected allow to address research question?	Q1 Qualitative approach appropriate?	Q2 Qualitative data collection adequate?	Q3 Findings adequately derived?	Q4 Interpretation sufficiently substantiated?	Q5 Coherence between data sources, collection, analysis & interpretation?	Overall rating (Code at end of table)
Franzen and Gottzen 2011	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Smithson 2011a	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Smithson 2011b	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	****
Sharkey 2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Westerlund 2013	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	****
Seko 2015	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Westerlund 2015	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Ma 2016	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****

Gritton 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Wong 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Brown 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Fratini & Hemer 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Lavis & Winter 2020	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	****
Islam 2021	Yes	Yes	Yes	No	Yes	No	No	**
Stanicke 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Zhu 2022	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	***
Balt 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Moir 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Thorn 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Dekel 2024	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Hatfield 2024	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****
Quantitative Descriptive								
	Screen: Clear research questions?	Screen: Data collected allow to address research questions?	Q1: Sampling strategy relevant?	Q2: Sample representative of target population?	Q3: Measurements appropriate?	Q4: Non-response bias low?	Statistical analysis appropriate?	
Jones 2011	Yes	Yes	Yes	No	Yes	No	Yes	***
Cash 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*****

Pritchard 2021	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	***
Walker 2024	Yes	Yes	Yes	No	Yes	No	Yes	***
Quantitative Non-Randomised								
	Screen: Clear research questions?	Screen: Data collected allow to address research questions?	Q1: Are participants representative ?	Q2: Are measurements appropriate?	Q3: Are outcome data complete?	Q4: Are confounders accounted for?	Q5: Intervention administered (/exposure occurred) appropriately?	
Corbitt-Hall 2019	Yes	Yes	No	Yes	Yes	Yes	Yes	****
Liu 2019	Yes	Yes	No	Yes	Can't tell	No	Can't tell	*
Lee 2022	Yes	Yes	Yes	No	Yes	Yes	Yes	****
Quantitative Randomised Controlled Trial								
	Clear research question?	Data collected allow to address research questions?	Randomisation appropriately performed?	Baseline groups comparable?	Complete outcome data?	Outcome assessors blinded?	Participants adhere to intervention?	
Corbitt-Hall 2016	Yes	Yes	Can't tell	Can't tell	Can't tell	No	Yes	*
Mixed methods								
	Clear research questions?	Data collected allow to address research	Adequate rationale for	Different components adequately	Outputs of qual. and quant. components	Divergences adequately	Do different component	

		questions?	mixed method?	integrated?	adequately interpreted?	addressed?	adhere to quality criteria?	
Avery 2016	Yes	Yes	Yes	No	No	No	No	*
Tan 2017	Yes	Yes	Yes	Yes	No	No	No	**
Fulcher 2020	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	****
Simms 2020	Yes	Yes	Yes	Yes	Yes	Yes	No	****
Quality appraisal range is * to ***; * = lowest quality, ***** = highest quality**								

Data Extraction

Study information was collated onto data extraction form, including main findings relating to disclosure. A sample of 50% of the texts was rated by two reviewers (RQ and CE), who then discussed discrepancies.

Data Synthesis

Narrative synthesis was used to synthesise papers and their findings. This was chosen due to the expected heterogeneity of study aims and methods. It allows a flexible yet systematic approach for varied research, strengths in bridging divides between research, practice, and policy (Madden et al., 2018); an advantage of particular importance given the topic.

Results

The included papers can be seen described in Table 2, with findings categorised as SM type, *N* (participants and/or data items), country, method, focus, main question, and findings. Characteristics are described below, with results split into process and impact of disclosure. A conceptual map was devised (Figure 2) to visualise the relationships and connections discussed within this section, illustrating the double-edged sword.

Table 2

Data Extraction

Main author(s) and date	N (participants)	N (data items)	Age (years)	Social media	Country	Method	Focus	Question	Findings
Franzen and Gottzen 2011	8		15-27, Mean 20.5	Self-harm web community	Sweden	Qualitative, using positioning theory and a poststructuralist perspective	What is disclosed	How young people in a virtual self-injury community construct themselves as cutters	Members frame identity constructions using normalising and pathologising discourses.
Jones 2011*	47		16-25, Mean 19	SharpTalk	UK	Mixed-methods: Surveys/questionnaires; descriptive statistics and qualifying quotes	Why disclose	What young people who self-harm think about online self-harm discussion forums	People learn more from online discussion forums than information sites, find it easier to talk about self-harm to strangers than to family or friends; prefer to talk online. Anonymity valued; more able to disclose and less likely to be judged online than in 'real life'.
Smithson 2011*		All threads on the forum (number unknow	16-25	SharpTalk	UK	Qualitative discursive approach, using discursive psychology, conversation	What people disclose and how people respond	How do people become members and sustain membership on self-harm forum	Participants display expectations about appropriate ways of discussing self-harm, and about responses and advice. New posters reference other self-harm sites, provide bio-medicalised narratives of their story, and ask for help in particular ways. Participants actively shaped interactions on the forum. On the SharpTalk site,

	n)				analysis, & membership categorisation analysis			perceived deviance in posting behaviour and health care advice giving were typically addressed by forum users, rather than by site moderators.
Smithson 2011*	Unknown	16-25	SharpTalk	UK	Qualitative Conversation Analysis	What people disclose and how people respond	How problems are presented on self-harm forum, what responses do they receive, & what is the nature of advice given	Tendency to offer advice where it was not asked for; mundane 'safe' nature of advice.
Sharkey 2012*	Unknown	16-25	SharpTalk	UK	Qualitative discourse analysis	What is disclosed	How young people who self-harm behave online, and how professionals might engage with them	Prevalence of disclaimers, hedges, questions, & tags in the young people's online interactions. A range of mitigation devices are used; young people orientate to a 'protective' line in their supportive interactions.
Cash 2013	64 comments	13-24	MySpace	US	Qualitative content analysis	What is disclosed	What content themes are there for posts relating to potential suicidality	Subthemes: Relationships, mental health, substance use/abuse, method of suicide, and statements without context. Comments referenced a significant amount of hopelessness, despair, and desperation.
Westerlund 2013	Forum conversations over 22 days	Estimated mostly teenagers and young adults in	SUIGUI CHAT	Sweden	Qualitative, Virtual ethnography, Critical Discourse Analysis	What is disclosed, how people respond	Why do people participate in conversations about suicide? What explanations/beliefs/di	Most participants communicate based on need to recognise themselves in others & to receive acknowledgement for their experiences, thereby gaining acceptance. There are also destructive elements through exchange of suicide methods & suicide encouragement.

		within 2-hour window	their twenties					scourses about suicide are constructed by participants? Which experiences are communicated in conversations? How are boundaries established & maintained on the forum?	Participants practise suicide behaviour in a mediated, conversational form, making the act seem less fearful. The participants are involved in constructing & re-constructing a counter-discourse in which established society's perceptions and values concerning suicide are questioned, expressing a critique against public institutions e.g. psychiatry.
Seko 2015	17		16-27, mean 19.94	Self-Injury.net, Tumblr, Blogger/Word Press, YouTube, DeviantART		Qualitative interviews, thematic analysis	Why disclose	Motivations for creating Non-Suicidal Self-Injury content online	Two prominent motives: self-oriented motivation (to express self and creativity, to reflect on NSSI experience, to mitigate self-destructive urges) & social motivation (to support similar others, to seek out peers, to raise social awareness). Double-edged impact of NSSI content both as a trigger & a deterrent to NSSI.
Westerlund 2015	1	638 messages	21	Flashback (Swedish forum)	Sweden	Mixed-method: qualitative investigation of messages posted before suicide & combined qualitative–	What is disclosed, how people respond	What forum messages are posted before, during, and after a cybersuicide	Nearly half the posted messages before the suicide encouraged the victim to complete the suicidal act, some posts after the suicide expressed excitement; around half of the posts considered the suicide to be tragic.

						quantitative analysis of messages posted during/after the suicide			
Avery 2016	1	50 videos	17 (case study); 58% of videos estimated to be under 20	YouTube	Mostly US	Quant descriptive statistics	Self-harm challenges	Present case report and analyse injury patterns from the fire challenge found on YouTube	13 videos included postburn footage demonstrating burn wounds of various location, size, and severity; these burns were not as severe as the case study. Of the 50 videos reviewed, 45/50 participants (90%) were male and 32/50 (64%) were African American with 29/50 participants (58%) estimated to be under age 20.
Corbitt-Hall 2016**	468		19–26, mean 20.33	Facebook	US	Quantitative randomised study; questionnaires	How people respond	Can participants recall, recognise, & interpret suicidal content on a simulated Facebook feed, & what actions are taken in response to newsfeed suicidal content contained	A larger proportion of those exposed to content reflecting moderate and severe suicide risk noticed, recognised, appropriately interpreted, and endorsed taking action to intervene, as compared to those exposed to content representing no or low risk.
Ma 2016	6	190 documents	19-24, mean 21.6	Weibo	China	Qualitative multiple case study approach,	What people disclose, how people	Identification of behavioural patterns during live-broadcast	Five distinct live-broadcast suicide incidents stages: Signalling, initial reactions, live blogcast of suicide attempts, crisis responses, final outcomes.

					grounded theory	respond	suicide events; examination of audience reactions and crisis response behaviours; analysis of the communication processes and signals exhibited by individuals during the broadcasts	Audience behaviour: Varied responses from viewers, including comforting messages, verbal abuse, and attempts to intervene. Communication patterns: Individuals often displayed signs of distress and issued cries for help during broadcasts. Opportunities for intervention: Live presentations of suicidal behaviours provided unique chances for real-time crisis response and intervention. Need for education: Many audience members wished to help but lacked the necessary skills or knowledge.
Gritton 2017	32	14-22		US	Qualitative focus groups, constant comparative method	How people respond	Adolescents' perspectives on concerning social media posts, incl. those expressing suicidal intent	Main themes: 1) youth typically respond alone; 2) barriers to action; 3) recommended training and support – trusted adults, anonymity, and privacy.
Tan 2017	Study 1: 17, Study 2: 725	mean 21.22	Weibo	China	Mixed-method: Interviews and surveys with descriptive statistics	What are acceptable responses to disclosure	Feedback on the acceptability of the content of direct messaging intervention for social media users with suicide ideation	Most participants would be most drawn to an intervention where account was known as reliable. Participants not opposed to online suicide intervention and valued the link for extra suicide intervention information if the account appeared trustworthy. Three important elements were found regarding the direct message: reliability of account name, brevity of message, and details of the phone numbers of

									psychological intervention centres and psychological assessment.
Wong 2017	1		22	Facebook	China	Qualitative case study, descriptive	What people post	What suicide decedent posted	Case study did communicate her suicidal wishes with someone in a context of hopelessness stimulated by the sense of loss in physical and mental health. The internet was the channel through which the girl connected to the outside world while she was mainly homebound.
Corbitt-Hall 2019**	690		Mean 20.24	Facebook	US	Quantitative online experimental	How people respond	Factors impacting response to suicidality disclosure	Only 33.6% of participants left a positive, supportive comment on at least one of the two suicide posts. Content severity, experience with a loved one's suicide attempts, & use of Facebook to meet people were predictive of providing positive comments.
Liu 2019		27,007 comments	Mean 21.66	Microblog of a suicide decedent	China	Quantitative	How people respond (intervention)	Is a crisis management intervention acceptable and helpful	Automatic identification of suicidal thoughts and behaviours along with proactive suicide prevention are acceptable and helpful.
Brown 2020	59		mean 16.7	Instagram	Germany	Qualitative; interviews	Why do people disclose	Motivation for and their experiences with posting NSSI content online	Motivations for posting self-harm pictures online mainly social (connection, disclosure, communication), while self-focused reasons like documenting NSSI or recovery were also mentioned. All participants reported receiving positive reactions (being offered help, connecting, receiving empathy), as well as negative comments (harassment, being misunderstood) to their own NSSI content by other Instagram users. None mentioned

								successful referral to professional help through their online NSSI activity.
Fratini and Hemer 2020	3		18-20	YouTube, Twitter, Chateen	Qualitative case study, anthropological	What do people disclose (cybersuicide)	What are the anthropological concepts of performance of cybersuicide	A public and social act, cybersuicide needs to be analysed in terms of how an audience is attracted and retained, as well as the key roles the audience plays in the social practice. This means that cybersuicide has a different structure from suicide offline.
Fulcher 2020		8772 captions and comments	Mean 16 (only 34% shared age)	Instagram	Mixed-method; observational, cross-sectional study using text and visual content analysis	What is disclosed	Hashtag/word frequency, visual content features, author demographics and aesthetics on unbanned variant of #selfharm	#depression and #suicide most commonly used hashtags after #selfharn, negative emotional tone, frequent wounds, lack of warnings, mostly female teen authors.
Lavis and Winter 2020	10	10,169 posts, 36,934 comments	10-24; young adults over 18	Twitter, Reddit, and Instagram	Qual online ethnography on social media at two timepoints; semi-structured interviews	What is disclosed, why disclose	Content analysis of posts using iterative thematic analysis, interviews on engagement with self-harm social media content	Peer support is the central component of online interactions around self-harm. Young people accessing such content are likely to already be self-harming; they may turn to social media to understand, and seek help for, their actions and feelings in a context of offline stigma and service support gaps.
Simms 2020		1,468 tweets	14-18	Twitter	Mixed-method inductive thematic analysis,	How people respond	To what extent do transgender youths' tweet about self-harm	133 (56.6%) received no public replies to tweets mentioning mental health issues. Of the 102 (43.4%) accounts that did receive public replies, 64 (62.7%)

						correlational statistical tests		and suicidality, how do their peers respond, and whether this differs from existing findings regarding the general population of young people on social media	received a maximum of two replies. The strongest correlation with receiving any reply was a moderate one with suicidal thoughts (r = .473, p < .005), followed by self-harm (r = .300, p < .005). There were moderate to weak significant correlations between replies expressing a similar experience and all defined tweet themes, the strongest being suicidal thoughts (r = .348, p < .005). While it occurred in replies to only 3.8% (N = 9) of accounts, the theme of advice was moderately significantly correlated with self-harm (r = .665, p < .005), followed by suicidal thoughts (r = .474, p < .005).
Islam 2021	9		18-32, mean 22.56	Facebook	Bangladesh	Qualitative case series	Who discloses prior to suicide	Who posts on social media prior to suicide, what do they post	Facebook can be a potential tool to predict and prevent such suicide cases. Students and young adults were the most vulnerable group for using Facebook during suicide. Relationship problems, academic stress, and future career uncertainty were key provoking factors.
Pritchard 2021		3,500 posts made by 2,799 users	13-24	TalkLife		Quantitative coding rubric	What is disclosed	What is post content, are there differences in time of day and day of week	Posts relating to suicidal ideation or behaviour 23.5%, documenting self-harm urges 12.3%, documenting recent self-harm 6.7%, asking for social support/reaching out 6.2%, documenting progress or cessation 5.7%, past self-harm 5.2%, sharing NSSI information 3.6%. Individuals are more likely to post about suicidal ideation or behaviour between 9 PM-11:59

							PM and less frequently between 12 AM-2:59 AM.
Lee 2022	249	19-30		Quantitative online survey	Who discloses	Comparison of people who self-injure only vs people who self-injure and post about it online	Compared to the NSSI only group, the NSSI online group showed higher intrapersonal functions of NSSI, self-injury craving, suicidal ideation, and past suicide attempts, along with lower resilience and self-esteem. The clinical risk factor, suicidal ideation, was closely associated with the frequency of these postings.
Stanicke 2022	16	18–23	Norway	Qualitative Interviews, IPA	Why disclose	How do young persons with a history of self-harm during adolescence make meaning of involvement in self-harm content online	(1) ‘Solitude during adolescence—finally found a place to fit in’, (2) ‘Tempting but dangerous—a game that never should end’, (3) ‘Searching for self—it was like an online diary’ and (4) ‘No one in charge’. Online activity became an opportunity for most participants to increase knowledge and social exploration; being online was an important way to connect with others and to be noticed. Reposting others' self-harm online content was a way to express feelings and distressful experiences. In this way, involvement in self-harm content online became way to regulate difficult feelings and thoughts. Online activity described more like writing an online diary.
Zhu 2022	7	11-19, mean 15.57	China	Qualitative analysis of published reports and social media entries; thematic	Online suicide challenge	What are the themes in Blue Whale Challenge victim antecedents, behaviours, and	Predisposition phase (low mood, interpersonal problems, poor school performance) followed by a five-stage process of Blue Whale Challenge involvement: 1) contact with a death-oriented game; 2) acceptance of the game’s rules and the escalating challenges; 3)

				analysis		consequences	challenge incidents conclusion – a suicide attempt/completion; 4) discovery by others and/or game rejection, followed by 5) personal recovery.
Balt 2023	35 cases, 55 interviewed	Mean 17 (all under 20)	Netherlands	Qualitative observational psychological autopsy study; interviews IPA	What suicide completers disclose, how people respond	Examining the meaning of social media in the lives of young suicide victims	A small group of adolescents who communicated often and openly about their suicidal thoughts developed a 'suicidal identity'. This transcended frequent suicide-related communication, as it maintained that the young person became so entangled with their own suicidal thoughts/behaviours that they found it hard to imagine their life without them. These adolescents were afraid of who they would be once they recovered because their mental health problems provided them with a sense of belonging and identity. Next-of-kin worried that cultivating an identity around suicidal thoughts and behaviours, and specifically the fear of letting go of this identity, aggravated suicidal thoughts and hampered help seeking and openness to treatment and recovery.
Moir 2023	3	18-21		Qualitative thematic analysis	What suicide completers disclose, how people respond	Exploring final communications of individuals to understand how internet is involved, how individuals who are online can	Suicides were encouraged and baited by their audience, often as the audience doubted legitimacy of the events, resulting in pride issues for the victim. Audience excitement was also present, suggesting that online communications feel more like entertainment than real life. Other themes include social disorders, hesitation, manipulation, and attention seeking behaviour related to

						influence	low self-esteem. Those who die online by suicide have moments of hesitation.
Thorn 2023	20	18-25	Australia	Qualitative interviews; thematic analysis	Why disclose	Why young people communicate online about self-harm, and the perceived benefits and harms of these communications	Main themes: (1) crossing from offline to online - the double-edged affordances of social media: young people engaged in online communication about self-harm because they were unable/unwilling to disclose in offline contexts. Online spaces afford anonymity and peer support, associated with benefits and harms; (2) user-generated is not quite the same as user-resonated: perceptions were influenced by whether the young person created or viewed or responded to the content. Written and visual content had pros and cons; (3) it's not just you, it's mostly me - individual characteristics influence perceptions: age and mental state influenced perceptions and behaviour; and (4) beyond individuals - parameters are protective: leadership and platform policies and procedures aided safety.
Dekel 2024	27	16-24	UK	Qualitative interviews, inductive thematic analysis	Why disclose	Motivation and impacts of sharing self-harm imagery online	Potential reasons for sharing self-harm images: attention seeking, seeking help/connection, raising awareness and expressing pain/creative expression. The importance of having a platform to share distressing experiences and to feel less isolated for people who do not have anyone to turn to.

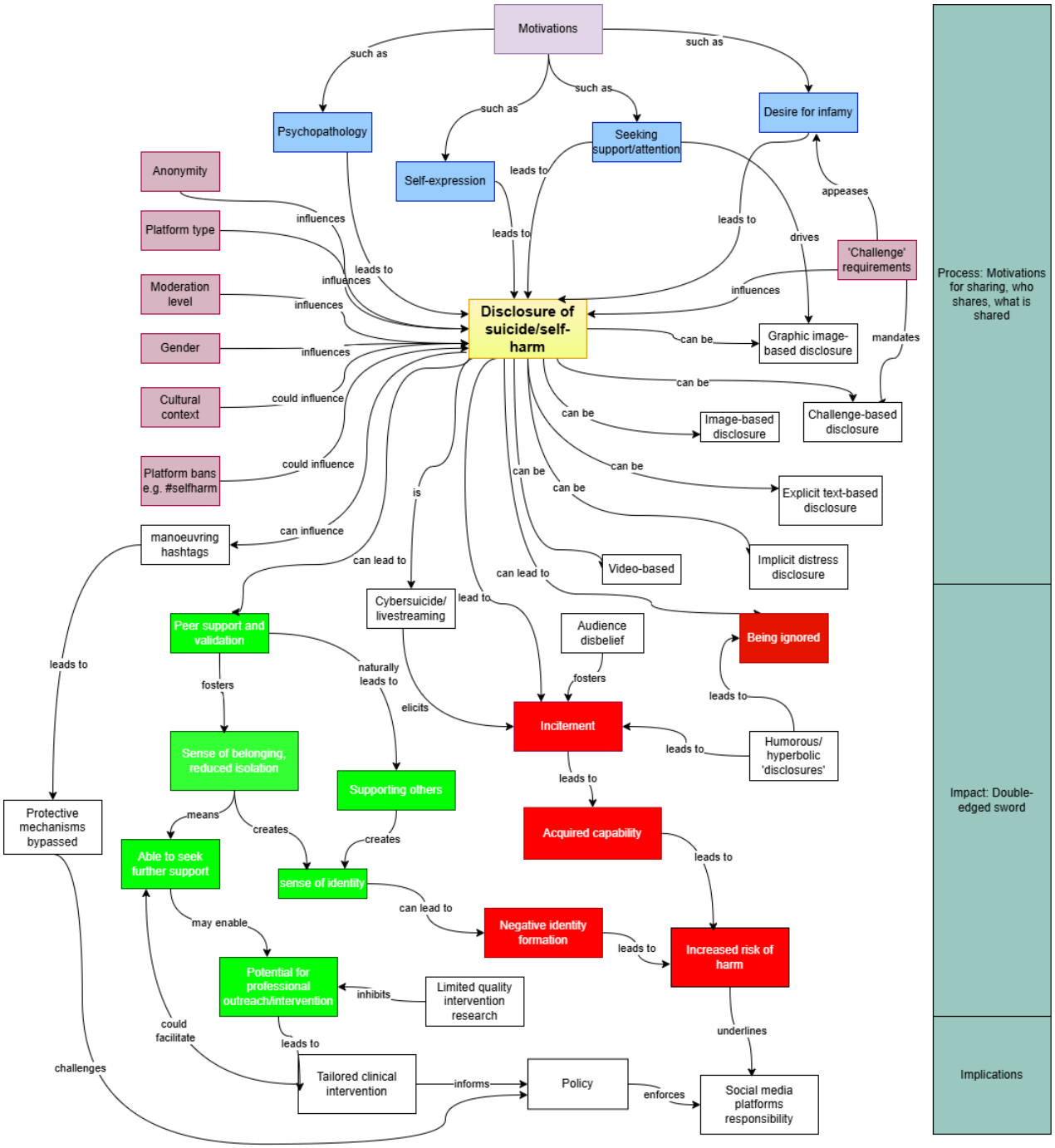
Hatfield 2024	2	17-23	Tumblr/Twitter	US	Qualitative; thick description for data backup	What suicide completers disclose	What was shared in suicide notes	Young trans individuals use social media to post suicide letters as unedited final statements, typically explain reasons for their decision, often involving family rejection and lack of access to gender-affirming care. They express grief over futures they were unable to realise. Written in the subjunctive voice, the letters focus on the moment before death, allowing readers to engage with the experience. By sharing these letters publicly, social media users create spaces for collective witnessing and mourning. This practice functions as both a disclosure of suicidality and a call for social change, highlighting systemic issues faced by trans people.
Walker 2024	89	15-18 Mean 16	Instagram		Quantitative linguistic analysis, regression	What suicide completers disclose	Linguistical features of Instagram captions	Significant differences between suicide decedents and living controls were found. Adolescent suicide decedents used more words per sentence, more references to sadness, male individuals, drives, and leisure and fewer verbs and references to they, affiliation, achievement, and power.

Studies marked with an * and ** respectively are groups of studies using the same sample. They have remained included in this review as their focus of analyses are different, but this has been considered during synthesis.

Abbreviations: NSSI, Non-suicidal self injury

Figure 2

Conceptual map of findings



Characteristics of studies

Following full-text screening, 33 studies were included: 21 qualitative, six quantitative, and six mixed methods. Per inclusion criteria, studies had a majority population within ages 15-24, though the total range stretched beyond this, and for some studies, given the anonymity afforded by online platforms, age was estimated rather than certain. Four papers and two papers respectively drew from shared samples, indicated in Table 2 with an asterisk. Nine studies were either global or did not state a location. The highest number of papers from one country was the US (N=6), followed by the UK (N=5), China (N=4) and Sweden (N=3), with eight other countries also represented. Sixteen papers predominantly focused on suicide, 15 on self-harm, and two a roughly even mix.

Research question 1: Process of disclosing suicidality and self-harm on SM

Core themes and findings relating to the process of disclosure are described below. Process includes why people disclose on SM, what they disclose, and who discloses.

Motivation for sharing. Nine studies explored motivations for youth sharing self-harm and suicide-related content on SM. Varied motivations were found, revealing varied personal and social reasons. The most common was seeking support and attention, cited by six studies (Dekel et al., 2024; Gritton et al., 2017; Hatfield, 2024; Lavis & Winter, 2020; Stanicke, 2023; Thorn et al., 2023). This was followed by wanting to reflect on and document self-harm, and looking to connect and communicate with peers, (both found in four studies).

Differences in motives found may be shaped by the sample selection methods, for instance Seko et al. (2015) found a relatively balanced split between personal

motivations, such as expressing oneself creatively, and social motivations, including seeking support. Conversely, Jones et al. (2011) found more social motivators, including feeling less judged and constant support. Within Seko et al.'s sample, participants tended to share artistic content (e.g. poems), consequently interviews focused on this, whereas Jones et al. sampled individuals using a written self-harm support forum. Additionally, some motivations may be specific to self-harm/suicide forums (compared with general SM), such as 'you don't have to censor' (Jones et al., 2011). Some papers described the use of SM as a means to reduce urges (Seko et al., 2015), in contrast to the assumption that disclosure would be associated with increased focus. Overall, motivations are varied, typically falling within either social or personal motivations, and varying across platform and content type.

***Online Challenges*.** A minority of studies examined harm-related content was framed by a challenge, which appeared to have different motivational drivers. Avery et al. (2016) described a 'Fire Challenge', where youths film self-infliction of flame injuries posited as stemming from motivations of lure of the challenge and potential to go viral. Zhu et al. (2023) observed the 'Blue Whale Challenge', involving a series of escalating tasks leading to suicide, through case studies. They conversely identified a 'predisposition phase', characterised by low mood, suicidality, poor school performance, and interpersonal difficulties, perhaps indicating that certain youths are drawn to different challenges.

What is disclosed. Content disclosed on SM varied significantly in its form and explicitness. Some shared text-based disclosures such as poetry, captions, and suicide notes (Fulcher et al., 2020; Hatfield, 2024; Seko et al., 2015). Others shared images and videos (Avery et al., 2016; Dekel et al., 2024).

Text-based disclosure. Fifteen studies described explicit text-based disclosure (Cash et al., 2013; Franzén & Gottzén, 2011; Fratini & Hemer, 2020; Hatfield, 2024; Islam et al., 2021; Lavis & Winter, 2020; Liu et al., 2019; Moir et al., 2023; Pritchard et al., 2021; Simms, 2020; Smithson et al., 2011a, 2011b; Stanicke, 2023; Thorn et al., 2023; Wong et al., 2017). Examples include “I’m cut open” (Franzén & Gottzén, 2011), and “almost succeeded…hung myself, but the rope loosed” (Westerlund, 2013). One study described how transgender youths used scheduled posting to share suicide notes posthumously (Hatfield, 2024). Cash et al. (2013) found 42% of suicide related comments on MySpace related to a relationship, with break-ups being most prevalent.

Two studies found that to be accepted, disclosers had to carefully construct their narratives disclosures by balancing a normalising and pathologising perspective (Franzén & Gottzén, 2011). Smithson et al. (2011a) corroborate this, finding people shared biomedicalised backgrounds to legitimise themselves and their experiences.

Not all text-based disclosure is overt. One study of 89 suicide decedent youths, found no explicit self-harm or suicide-related posts, however expressions of feeling depressed, unworthy, or posting an ambiguous apology were found on SM prior to suicide (Walker et al., 2024). Similarly, Ma et al. (2016) found that pre-suicide disclosure for some only contained reference to being unhappy or lonely. Thus, ‘disclosures’ of suicidality may be more nuanced than expected. To evade bans by platforms of triggering hashtags, users employed ‘manoeuvring hashtags’ such as #selfharn (Fulcher et al., 2020). This lack of clarity in identifying disclosure, and therefore risk, is further complicated by findings that young people may joke about suicide, or quote song lyrics that mimic suicidal intent (Gritton et al., 2017).

Image-based disclosures. Thorn et al. (2023) found that image-based disclosures were more common during a crisis. Seko et al. (2015) found many participants had a keen awareness of how triggering some graphic photographs could be, putting trigger warnings to notify others. Most participants in Brown et al.'s (2020) study reported graphic self-harm images gained more attention on SM compared with other photos.

Livestreams. Suicide livestreams were described by a small number of papers (Fratini & Hemer, 2020; Islam et al., 2021; Ma et al., 2016; Westerlund, 2013). These varied in disclosure content, with some suicide decedents explicitly signposting suicide to obtain an audience, and others ‘vaguebooking’, (vague posts that elicit attention), perhaps to attract unsuspecting viewers who may otherwise choose not to watch (Fratini & Hemer, 2020); Ma et al. (2016) identified several stages, including an initial signalling phase, possibly mirroring the more typical suicidal ideation disclosures. Fratini & Hemer (2020) posit that cybersuicide (death facilitated through the internet, e.g. via livestream) has a different structure to suicide, impacting how it should be analysed.

Who discloses. The main findings regarding who discloses related to gender, suggesting men and women disclose different things.

Gender. Studies primarily focused on self-harm disclosure had a consistent female predominance, typically ranging from 69.1-94.8%, indicating women and girls are far more likely to share such content online. The most significant exception to this trend is Avery et al.'s (2016) study on the Fire Challenge, which found a stark male predominance (90% male). This discrepancy suggests that public, physically dangerous, ‘challenge’-based self-harm may appeal more to young men, contrasting

with the predominantly expressive or support-seeking nature of many other self-harm disclosures where young women are overrepresented.

The gender balance appeared more varied in studies primarily focused on suicidal ideation and completed suicides, though females often remained significantly represented, with a range of 22.8-88.8%. In studies specifically exploring suicidal ideation, such as Tan et al., (2017) and Liu et al. (2019), a strong female majority was found (84-88%), indicating young women more frequently express suicidal thoughts online. However, studies examining deaths by suicide through specific high-risk phenomena, such as live-broadcast suicides, tended to show a male overrepresentation, with only 22.2-33.3% being female (Fratini & Hemer, 2020; Islam et al., 2021; Ma et al., 2016). This suggests while women are more likely to disclose suicidal ideation on SM, young men may be more likely to proceed to attempt or complete suicide in public online contexts.

Aside from the case studies, the studies were mostly cross-sectional, making causal factors as to who shared difficult to infer. Lee et al. (2022) found that within a sample of people disclosing self-harm online, there were higher levels of intrapersonal functions of self-harm, self-injury craving, suicidal ideation, and past suicide attempts, along with lower resilience and self-esteem, compared with a sample who self-harmed but did not post about it. In this paper, it was not possible to tell whether the higher level of psychopathology leads to the use of SM, or whether the SM use fuels the distress.

Research question 2: Impact of disclosing suicidality and self-harm on SM

The impact of disclosure of suicidality and self-harm on SM presents a double-edged sword for the discloser, with positive and negative impacts, and personal differences affecting the impact disclosure has on individuals.

How people respond. The social nature of SM means discourses and responses can vary greatly.

Validation and emotional support. Many studies found SM disclosures were responded to with validation and emotional support (Brown et al., 2020; Lavis & Winter, 2020; Simms, 2020). Simms (2020) additionally highlighted themes of 'feeling the same way' and 'offering advice' within replies. In offering advice, others used mitigation devices such as 'hedges' (e.g. 'probably', 'kind of like') and questions to foster rapport (Sharkey et al., 2012)**, i**ndicating careful consideration of what disclosers need; an idea echoed by Smithson et al. (2011b). This may be because, as Simms (2020) found advice from peers is often shut down or negatively received, exemplified by repeated 'no' comments by the discloser in response to suggestions for help avenues. Two studies found that forum members would test a disclosers authenticity and motivation to confirm they 'deserved' validation, suggesting that what people disclose is shaped by others' reactions (Franzén & Gottzén, 2011; Westerlund, 2013). Positive findings were more likely to be found within highly moderated platforms, such as SharpTalk (Smithson et al., 2011b) compared with Livestream platforms (Fratini & Hemer, 2020; Ma et al., 2016).

Incitement. Examples of incitement were found in multiple studies, particularly those focused on cybersuicide. Cynical and baiting comments, including indicating a person 'deserves' to die and asking 'why are you still alive?', were found by Ma et al. (2016), and Moir et al. (2023) further found individuals were encouraged

towards suicide. Only one study referenced incitement as a response to self-harm, with one participant told to ‘cut myself to death’ (Brown et al., 2020), suggesting incitement is more common regarding suicide.

Inaction. Disclosure may be met with no response: Simms (2020) found that over half of transgender youths’ X (Twitter) posts about mental health issues were not replied to publicly, though tweets about suicide elicited more responses than those concerning mental health or self-harm. While this may paint a concerning picture, especially given the higher rates of suicide within this population, the study acknowledged private support e.g. Direct Messages was unobservable. Inaction was found to result from responder fatigue, and could lead to ‘unfriending’ (Gritton et al. 2017).

Interventions. Two studies specifically focused on the acceptability of a suicide prevention intervention via direct message following suicidal disclosure (Liu et al., 2019; Tan et al., 2017). Both Liu et al. and Tan et al. found most responders felt the intervention was acceptable (69% and 79% respectively), though less than half responded (44% and 17% respectively). In Liu et al.'s (2019) longitudinal study, a psychoeducation and counselling intervention led to reduced death-orientated words and increased future-orientated words; these findings are limited by the lack of a control group. Liu et al. (2019), in contrast with Tan et al. (2017), used machine learning to make the identification less resource-intensive.

Three studies examined peer response from the perspective of responders, with two papers (using the same sample) using experimental design, and one using focus groups (Corbitt-Hall et al., 2019; Corbitt-Hall et al., 2016; Gritton et al., 2017). Corbitt-Hall et al. (2019) found in their simulated Facebook study that only 33.6% of

people replied to an online disclosure of risk of suicide, and although most would take some form of action if the person was severe risk, such as contacting a close friend/family (88.4%), some still reported favouring no action. Social desirability bias and awareness of artificial nature of risk was may have influenced responses in this randomised study, resulting in low ecological validity.

Psychological outcomes of disclosure. Peer support on SM is described as helpful by many studies, with some describing this as “lifesaving” and as helping “you feel that you matter, and you’re not just drifting through the world disconnected” (Lavis & Winter, 2020). While this review does not focus on the impact of viewing and supporting others’ disclosures, it was clear the two cannot always be separated, particularly on forums where reciprocity is likely, with four studies discussing ‘expected’ mutual support (Lavis & Winter, 2020; Seko et al., 2015; Sharkey et al., 2012; Smithson et al., 2011b).

Two studies found a sense of identity was shaped through SM discourse (Balt et al., 2023; Franzén & Gottzén, 2011). Balt et al., (2023) found for a small number of suicidal decedents, a ‘suicidal identity’ was developed, and recovery would mean losing their identity anchor. Franzén & Gottzén (2011) found the main discourse found on self-harm communities was a ‘normalising’ one, framing self-cutters as strong and world-wise, though conflict was found with an alternative pathologising perspective on the behaviour. Seko et al. (2015), contrastingly, found engaging with self-harm forums helped one participant see they “didn’t have to let self-injury define me entirely” due to the diverse content even on a self-harm specific online space. Thorn et al. (2023) found individuals’ mental state at the time of communication was a key intrapersonal factor.

In summary, studies reveal the multifaceted nature of suicidality and self-harm disclosure among youth. Motivations for sharing are diverse, influencing the form and explicitness of content, while gender differences suggest distinct disclosure patterns. The impact of such disclosures is consistently framed as a double-edged sword, encompassing both supportive peer responses and significant risks like baiting and inaction. These findings highlight the complex interplay of individual characteristics, platform dynamics, and audience reactions, shaping the overall experience of SM disclosure. Findings will be considered in the context of theory, practice, policy, and future implications.

Discussion

This systematic review synthesises findings from 33 studies on the process and impact of disclosure of suicidality and self-harm on SM among youths aged 15-24 years old, using narrative synthesis. The findings show complex, nuanced, and often paradoxical patterns. A consistent theme was the double-edged sword of SM disclosure, offering both potential for support, and risk of harm. Although studies were generally constrained by self-selecting samples typically from niche platforms, limiting broad generalisability, the overall strength of qualitative methodologies afforded rich, nuanced understanding of individuals' experiences, which is crucial for this review. Whilst interpretation of results relies on the premise that data are accurate, SM users typically do not have to verify their age. This is important given Ofcom (2022) found 47% of children in the UK aged 8-15 have a SM account with a user age of 16.

Theoretical context will be considered first, followed by main findings interpretation, delineated by process and impact of disclosure. Methodological and quality considerations are synthesised throughout when interpreting findings, with additional

focus within the named section. Implications for clinical practice, SM platforms, policy, and research are then considered.

Interpretation of Results and Theoretical Context

Findings align with and extend Chaudoir & Fisher's (2010) Disclosure Processes Model. Approach goals for disclosure, such as seeking emotional support, validation, and belonging, were observed across many studies. Perceived online anonymity is a key mechanism that lessens inhibition, enabling disclosure by reducing fear of judgement and repercussions. The strength of some of the qualitative studies, particularly those using interviews, was their ability to capture these subjective experiences. The mediating role of social support, as per the model, is central, with many disclosers experiencing reduced isolation, and a sense of understanding.

SM introduces complexities that challenge or nuance the Disclosure Process Model. The ‘confidant’ shifts from a single individual to a large, often anonymous audience. This changes the personal bond and direct accountability typically seen within a disclosure process, perhaps explaining findings such as trolling and incitement that are less common within a dyadic disclosure. The ‘cost-benefit’ evaluation is arguably more complicated, and what might start as a pursuit of support driven by approach-focused goals may paradoxically lead to the reinforcement or escalation of harmful behaviours due to online dynamics for attention, validation, or to prove authenticity; a dimension not fully emphasised by the original Disclosure Process Model. This double-edged sword effect, found consistently across qualitative studies, including the higher-quality case studies, highlights a pattern of ambivalence. Given the negative impacts of incitement seen within the case studies it is important to understand this better. The Disclosure Processes Model’s focus on individual agency

is challenged by the external coercion seen in curator-manipulated ‘challenge’ behaviours, specific to certain online contexts.

The findings also fit within the sociological theories of suicide, such as Joiner's (2005) Interpersonal Theory of Suicide. Desire for connection, and thwarted belongingness, often drive youths towards online communities, seeking a sense of shared identity and understanding otherwise lacking in their offline lives. As per the model, this could be a protective drive and may be especially important within healthcare contexts where 24/7 support is not accessible. The SM environment, however, can perpetuate and exacerbate this thwarted belongingness if disclosures are met with silence, misinterpretation, or rejection. This highlights a critical possible negative feedback loop online, undermining the very belongingness sought by disclosers. Findings on what people post offers a confronting understanding of the distressing and possibly triggering nature of what can be shared online. Repeated exposure to one’s own injuries and written content, as well as others’, may relate to the ‘acquired capability’ component of Joiner's (2005) theory, whereby individuals become desensitised to pain and fear, often through repeated exposure. With most studies being cross-sectional, it is not possible to draw causal conclusions, and so further research would be required.

Process of Disclosure

Findings on process of disclosure are explored below.

Motivation. Various motivations were found, largely grouped into social and personal. Cybersuicides may be driven by alternative motivations, arguably driven by a desire for infamy rather than support-seeking, as per livestreamed suicides described by Fratini & Hemer (2020), or justice and validation in death, as seen in

suicide notes posted online (Hatfield, 2024). Some livestreamed suicides led to interceptions by observers (through obtaining attempters' IP address), possibly indicating that livestreamers' intentions were not as straightforward as absolute commitment to suicide. This idea is supported by (Moir et al., 2023) who identified mid-livestream hesitation, though only in one case study.

Motivation appears to significantly impact what is posted: this is corroborated by findings that disclosures in the form of graphic images might indicate a crisis (Thorn et al., 2023). Although these qualitative interview findings may not be extrapolatable beyond the Australian sample, this could highlight a possible intervention signifier. Brown et al.'s (2020) findings that disclosure posts provoked more attention than others may suggest that the online community is already understanding this motivation and is responding to need.

Sample characteristics may change interpretations of motivation. For instance, Dekel et al. (2024) found that some youths in their diverse sample perceived sharing self-harm online as attention seeking. In contrast, Lavis and Winter (2020) highlighted the sharing of content, particularly graphic self-harm material, to solicit help. This is particularly important within the UK-sample context of a resource-depleted NHS, as online peer support is available 24/7, a motivation corroborated by another UK-based study, Jones et al. (2011). The differences in these findings can partly be attributed to study population variances. Dekel et al.'s (2024) sample included youths with and without history of self-harm, with a majority being refugees, and of those who had self-harmed, none had posted online. Their study found that some participants, particularly the refugees, did not approach self-harm disclosures sympathetically. This may indicate motivations to not post, along with highlighting cultural contexts where self-harm is more stigmatised, and fear of repercussions due

to unsettled status. This unsympathetic approach contrasts with studies like Lavis and Winter (2020) and Jones et al. (2011), which primarily sampled individuals who were self-harmers. These samples were more likely to frame disclosure as seeking and providing genuine support, reflecting a lived experience understanding.

Gender Differences in Disclosure Patterns. While studies did not provide sufficient data to draw conclusions about distinct pattern findings for age subgroups, gender differences were apparent. Findings that young women are more likely to disclose ideation and self-harm aligns with research showing women seek and provide social support more frequently (Belle, 1991). This may shed light on motivations for posting. Findings that young men were overrepresented in cybersuicides could be an artefact of small samples within case series, indicate that the public, performative nature of cybersuicide particularly appeals to men, or simply reflect established demographic trends where a higher proportion of men end their own lives (Office for National Statistics, 2024). The reviewed literature does not provide means to draw conclusions regarding this. For studies with transgender populations, negative responses such as incitement were not seen (Simms, 2020), perhaps indicating findings from cisgender samples cannot be generalised. This study, however, like many of the reviewed, only focused on publicly available data (e.g. tweets from public accounts), and may therefore be biased, missing key impacts both in real life and in private inboxes.

Impact of disclosure

Notwithstanding the quality limitations of some of the studies, the literature provides a helpful context of the impact of disclosure on SM.

Benefits of Disclosure. Some studies highlighted beneficial impacts of disclosing suicidality. The association between benefits of disclosure and highly moderated platforms may indicate the need for more regulation, though increasing moderation may simply push suicidal youths further into online fringes. Disclosure does not happen in a vacuum, and although this review focuses on impact of disclosure, findings should be considered alongside those reviews that looked at impact of viewing of self-harm and suicide content, such as that by Susi et al. (2023).

Negative Impacts of Disclosure. Negative impacts of disclosure were also found, such as inaction and incitement. Literature on the contextual language seen on SM may shed light on why inaction happens: hyperbolic, humorous use of self-harm and suicide related terms is common on SM (Ali et al., 2024). Some of the cases presented in the cross-sectional case series that were faced with incitement sadly ended their lives, however it is not possible to identify causal links. There are, of course, ethical challenges of investigating this experimentally within an at-risk population. Inherently, those with the most severe outcome, suicide, for whom our understanding is arguably most important, cannot have their views directly studied.

Intervention. There was tentative evidence in support of proactive outreach on SM (Liu et al., 2019; Tan et al., 2017), though this was of poor quality and so should be interpreted cautiously. This research was specific to Weibo and a Chinese population, limiting its generalisability. Further research is needed to understand whether interventions are acceptable and helpful.

Grappling with Risk of Harm. Governments are increasingly becoming aware of the risk of harm and placing greater responsibility on SM companies to protect youths. The Online Safety Act (2023) places significant legal duties on SM

platforms, emphasising the importance of limiting SM access, and specifically access to harmful content, for children. While the plethora of deleterious effects identified by this review may mean this legislation is necessary to reduce harm, findings from Lavis & Winter (2020) support the idea that youths turn to SM to cope with pre-existing, offline self-harm, to make sense of and cope with their experiences. This refutes contagion theories, instead positing SM as a powerful tool for support (Lavis & Winter, 2020). Though this study used ethnographic forum data to supplement interviews (a strength), they provided fieldnote extracts rather than illustrative examples to preserve anonymity, limiting quality by preventing finding verification. Longitudinal and larger-scale research would help to understand the risk of contagion, thus better informing policy and legislation. A one-size-fits-all ban of content would not only likely be creatively overcome, as shown by the ‘selfharn’ hashtag in Fulcher et al. (2020), but also may limit a vital source of support for some.

Methodological and Quality Considerations

The quality appraisal using the MMAT (Hong et al., 2018) revealed patterns within the reviewed studies. These methodological choices and differences shaped the types of process and impact identified and the conclusions that can be drawn. Consideration of the methodological quality of the included studies added important nuance for the double-edged sword finding. When prioritising the findings from higher-quality papers, such as those rated four or five stars in the MMAT appraisal (Table 1), a distinct pattern emerged regarding the evidence supporting each ‘edge’ of the sword, with the benefits of disclosure predominantly supported by the most methodologically robust studies.

Within the review, high-quality qualitative studies rated as four or five stars included Brown et al., 2020, Dekel et al., 2024, Hatfield, 2024, Moir et al., 2023, Seko et al., 2015, Stanicke, 2023 and Thorn et al., 2023. These papers allowed a rich understanding of complex phenomena, including the subjective motivations and meaning-making processes behind online disclosure, though have limited generalisability. These are likely to be papers where conclusions may be more confidently drawn from, given their robust methods. Rigorous five-star interview studies such as those by Thorn et al. (2023) and Stanicke (2023) provided credible, in-depth evidence of supportive functions.

Conversely, while the harms of disclosure are clearly documented and extremely serious, the evidence of the most severe negative outcomes, such as direct incitement to suicide, came from observational case studies or descriptive analyses of online content like those from Ma et al. (2016) and Moir et al. (2023). While these studies provided vital real-world examples of the risks, their methodological design is less robust than the in-depth interview studies. Case studies present an important methodological consideration, particularly those that focus on suicide attempts and completion (Islam et al., 2021; Ma et al., 2016; Moir et al., 2023; Westerlund et al., 2015; Zhu et al., 2023). Whilst providing helpful real-world examples of the ‘what’ of suicide disclosure (and arguably less impacted by social desirability bias compared with self-report research), they inherently present a selective view of impact. They may overstate the negative impacts by focusing only on disclosures that ended in harm or death. For instance, Ma et al. (2016), found positive responses, such as emotional support, given to some cases in the initial phases of disclosure. Nonetheless, per their inclusion criteria, all six individuals then went on to attempt suicide. Selective focus on these tragic instances, while important given the sad

outcome, risks missing the individuals who disclose online, receive positive outcomes, and find this meets their emotional needs. This could lead to the overstatement of prevalence of negative impacts and should be considered when interpreting this review's findings.

Noting the pattern within the literature that the strongest evidence typically aligns with the positive aspects of social media is not to downplay the very real dangers, but to refine the 'double-edged sword' conclusion. The highest quality evidence speaks to the supportive and community-building functions of these online spaces, while highlighting a need for more high-quality research to better understand the specific mechanisms and prevalence of these harmful interactions.

There is also a risk of sampling bias. Many studies relied on self-selected samples or recruitment from specific online communities, which could bias samples towards heavier users, who are more enmeshed with their online presence and identity. Conversely, individuals for whom SM does effectively meet their needs, may use SM to disclose less frequently, and therefore might not see and respond to adverts, or have less content included in studies using content as data.

Implications

When summarising the clinical implications of these findings, there is not a one-size-fits-all recommendation. Clinically, those working with youths who experience suicidality or self-harm should consider proactively asking about their SM use to explore the personal meaning and impact of any online disclosures. Tailored interventions may leverage the benefits of SM disclosure such as 24/7 peer support,

while exploring risk to ensure the youths are safe, supported, and protected from online harms.

SM platforms have a crucial responsibility to implement and enforce safety policies. This review found very tentative evidence for the effectiveness of proactive outreach to suicidal individuals, and further research is needed to explore this across platforms and create a more robust evidence base. One study found evidence that Machine Learning could be an avenue for risk identification, and this is supported by extant literature underlining the validity of these methods (Zheng et al., 2022). Policies should be sensitive to the nuances of online communication, such as coded language or the hyperbolic, joking use of ‘disclosure’. Blanket bans of content, without providing alternative support avenues, may inadvertently increase isolation for vulnerable youths.

The clinical implications point to safeguarding needs. The findings of this review underscore the complex safeguarding challenge presented by social media. On one hand, these platforms offer a vital space for young people to seek and receive peer support that they may not have access to offline, thus making a simple, restrictive approach to safeguarding inappropriate, as it risks removing a lifeline. On the other hand, the review clearly documents the significant risks of harm, from inaction to active incitement, creating a profound duty to safeguard for social media platforms and policymakers. The research therefore has direct implications for developing nuanced safeguarding strategies. It supports policy efforts like the Online Safety Act (2023) by providing evidence of the specific harms that need to be addressed, while also cautioning that blanket bans on content could be counterproductive. For platforms, it highlighted the need for more sophisticated moderation and the potential value of proactive outreach interventions. For clinicians, parents, and educators, the

importance of fostering digital literacy and having open conversations with young people about how to navigate these online spaces safely was emphasised. It is vital that researchers not only investigate these online phenomena but also model digital, participant, and researcher safeguarding.

Public health initiatives should educate youths about the risks of online challenges, promote safe communication, and empower them to respond effectively and safely to concerning disclosures.

Future research should address several gaps identified in the current evidence base. Longitudinal studies are critically needed to establish clearer causal pathways between online activities and mental health outcomes, including understanding what factors determine responses received. Investigations into the long-term impact of specific types of online support are warranted, along with further study of online interventions.

Limitations

The breadth of this topic means that findings for some sub-topics are based on only a few studies. Additionally, although studies primarily focus on disclosure, often other topics were enmeshed, such as the impact of viewing other people's disclosure content. This review included papers published since 2009. While providing a broad overview, SM functionality and user behaviour changes rapidly, limiting the relevance of findings in understanding modern usage, particularly given the shift from text-based content to visual and video (Gretzel, 2017). Even recent studies might not accurately reflect the current online environment, presenting challenges in drawing universally applicable conclusions.

Ethical constraints mean research often relies on self-reported, retrospective accounts, susceptible to recall and social desirability biases. Studies varied in their ethical approach to data collection: some felt it unethical to include qualitative information from SM, upholding anonymity, but at the cost of being able to verify if the data sufficiently substantiated findings. Some popular platforms, including Snapchat, were not featured in studies, possibly because it is a more private app. Research should explore ways to ethically investigate these.

The study did not include grey literature, which may mean findings were shaped by publication bias. In attempting to understand the experience for youth specifically, many articles looking at wholly anonymous content could not be included, despite its likely relevance given demographics of SM users. Conversely, some studies were included based on estimations of youth, though this could not be verified.

Conclusions

This review comprehensively synthesises evidence on the process and impact of youth disclosing suicidality and self-harm on SM. It highlights that online platforms serve as spaces for self-expression, help-seeking, and community-building, and can fulfil needs not met offline. These benefits, however, are tangled with significant risks, including normalisation and reinforcement of harmful behaviours. Disclosure impact is shaped by the nature of audience responses, which vastly vary from supportive to cruel. Understanding this is crucial for developing targeted interventions and for creating safety policies that protect youths without simply banning their access to this support. Current research offers a targeted but limited picture as to processes. Future efforts must prioritise nuanced approaches that

leverage support while mitigating harms, to ensure SM can become a safer, more effective tool for suicide and self-harm prevention among youth.

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Service Improvement Project: Understanding Neurodivergent Clients' Experience of the DBT Pathway within the Buckinghamshire Psychological Therapies Team

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Proposed Journal: Psychology and Psychotherapy: Theory Research and Practice. This journal psychosocial focuses on processes that underlie the development and improvement of mental wellbeing, with direct implications for the practice of psychological therapy. Practitioner Points, as required by this journal, are in Appendix A.

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Conflict of Interest Statement

The authors declare no conflicts of interest regarding the research, authorship, and/or publication of this article.

Abstract

Objectives: This Service Improvement Project aimed to understand the experience of neurodivergent individuals in accessing Dialectical Behaviour Therapy (DBT) within Buckinghamshire Psychological Therapies service, including barriers and facilitators to this, and to make recommendations for change.

Method: A mixed-method approach was used. Semi-structured interviews were conducted with ten neurodivergent DBT service users to explore their experience with the service; online qualitative surveys were completed by eleven staff. Thematic analysis was used to explore service user and staff experiences. Forty-two service users' group clinical data were analysed using descriptive statistics.

Results: For the service users, themes of 'I feel different', 'we are different', and 'being different within the mental health system: wider system helps and hinders agency' emerged. For staff, themes of 'uncertainty of diagnosis', 'staff are willing but constrained', and 'importance of a paced, flexible approach' arose. Notable dropout rates were found across DBT-informed groups for neurodivergent service users Clinical data confirmed that neurodivergent service users are more likely than neurotypicals to drop out of the DBT-informed group, even an adapted group.

Conclusions: Needs should be sensitively explored, and adaptations should be personalised. Qualitative findings support the continued use of the adapted group.

Keywords: neurodivergence, autism, ADHD, Dialectical Behaviour Therapy, service access

Introduction

Neurodivergence

Neurodivergence describes differences in how an individual's brain functions, processes, and learns information. Neurodivergence is an umbrella term, including Attention Deficit Hyperactivity Disorder (ADHD), autism, dyslexia, and dyspraxia; 15% of the population are estimated to be neurodivergent (Grainger & Grainger, 2021). When mentioning neurodivergence, however, this project will be referring to autism and ADHD only, given the service is offering an adapted Dialectical Behaviour Therapy (DBT) group for people reporting autism and/or ADHD.

Autism and ADHD

Autism is defined in the DSM-V as a neurodevelopmental condition with social communication, sensory, and information processing differences. ADHD is a neurodevelopmental disorder characterised by inattention, disorganisation, and/or hyperactivity-impulsivity (American Psychiatric Association, 2013). Autistic people tend to experience differences that interfere with effective emotion regulation (Reyes et al., 2019), and emotional dysregulation is a primary symptom for ADHD (Hirsch et al., 2018). Factors including alexithymia, cognitive rigidity, difficulty reading social cues, and environment stimulation can all impede emotion regulation (Mazefsky & White, 2014). Adults with ADHD versus without have been found to more frequently use non-adaptive emotion regulation strategies (Soler-Gutiérrez et al., 2023).

Dialectical Behaviour Therapy (DBT) and neurodivergence

DBT is a psychological therapy originally developed to reduce suicide attempts and self-injury behaviours (Linehan, 1981). Central to both theory and practice of DBT is

the focus on increasing clients' ability in experiencing and managing emotions, interpersonal relationships, and crises (Swales & Dunkley, 2020). Theoretically, DBT draws upon the biosocial theory to understand how an individual's difficulties within these areas develops over time: early biological vulnerability interacts with invalidating caregiving environments, leading to capability and motivation deficits primarily impacting emotion regulation (McMain et al., 2001). DBT aims to develop skills in managing distressing experiences and emotions (Linehan & Wilks, 2015).

Neurodivergent individuals can have unique needs in learning to manage distressing emotions. Social communication and repetitive behaviours can negatively influence emotion regulation (Martínez-González et al., 2022). Neurodivergence is associated with increased risk of mental health difficulties and suicide (Cassidy et al., 2018; Fuller-Thomson et al., 2022; Lai et al., 2019). Given the disproportionate prevalence of mental health difficulties amongst this population, it is prudent to consider how to meet their needs and make interventions accessible. Emerging evidence suggests that for neurodivergent adults, DBT is an effective treatment (Bemmouna et al., 2022; Halmøy et al., 2022). NICE guidelines recommend adaptations to therapy including physical environment adaptations, incorporating clients' special interests and scheduling breaks (NICE, 2021). Therapists can lack expertise in supporting neurodivergent individuals (Lipinski et al., 2022). It is essential that new research focuses on mainstream services' accessibility and investigates helpful adaptations.

Adapted versions of DBT exist aimed at individuals with developmental differences, including neurodivergence (Keenan et al., 2024). Research highlights the need to develop clinicians' understanding of autism to increase the acceptability and satisfaction of DBT services (Ritschel et al., 2022).

Service Context

Buckinghamshire Psychological Therapies (BPT) is a Step-4 psychology service offering group and individual psychological interventions for adults. Within the service is a DBT team, comprising Clinical Psychologists and DBT therapists. Any assessing clinician from the wider BPT service can refer to this modality, therefore individuals accessing the DBT pathway come through the main BPT service for assessment. The ‘DBT offer’ within BPT is full-package (year-long individual DBT therapy plus skills group), a 6-month skills group, or a 14-week Emotion Coping Skills (ECS) group (as per Neacsiu et al., 2014), depending on clinical need. The service recently implemented an adapted ECS group specifically for neurodivergent service users (SUs) after anecdotally noticing high referrals and drop-outs for this population. Full details of group adaptations are in Appendix B.

Questions to be addressed

Considering the need to ensure neurodivergent SUs can access DBT, a Service Improvement Project was created to explore these questions:

- What are SUs’ perspectives on the current ‘DBT offer’? Would changes/adaptations be needed to better meet needs of SUs, and if so what?
- What are staff perspectives on current ‘DBT offer’? How do they feel neurodivergent individuals are catered for? Would changes/adaptations help meet the needs of neurodivergent individuals, and if so what?

Method

Trainee joined BPT team meeting to crystallise projects aims. This project was defined as audit/service evaluation, thus approval was obtained from the Oxford

Audit Management and Tracking Team. Reporting is in line with Standards for Reporting Qualitative Research guidelines (Appendix C, O'Brien et al., 2014).

Design

Qualitative-only method was initially planned as research questions aimed to develop an inductive, in-depth understanding of SUs' experience, framed within an interpretive paradigm, entailing the premise that there are multiple, relative realities, individually constructed through language and shared meanings (Putnam & Banghart, 2017). Semi-structured interviews were conducted with SUs, allowing individuals to co-construct their personal experience with the interviewer, and allowing individual interview adaptations to be made. Recruitment was challenging. It was only possible to interview one participant from individual-DBT and no-one who had dropped out, therefore an additional quantitative component was added, to explore the adapted group accessibility. Emergent mixed-methods can be used when one aspect of the research is inadequate (Morse, 2009). Staff data collection was initially planned as a focus group, however due to time constraints, no-one was able to attend. Therefore, data collection was changed to an online survey, allowing flexibility in completion.

Altogether, an inductive, subjective, qualitative exploration was combined with a deductive, numerical approach to strengthen understanding of the group, allowing a rich, shared understanding of individuals' experience, with contextual attendance and drop-out data, to provide insights as to the group accessibility.

Position Statement

The lead researcher (RQ) is a neurotypical Trainee Clinical Psychologist, and previously completed a placement with BPT, including facilitating the non-adapted

ECS group, and adapting DBT content for neurodivergent SUs. This familiarity may have facilitated understanding in interviews, however, this may have stifled curiosity due to assumptions. Although an inductive approach was used, this previous experience likely shaped the interviews and data interpretation. It may have impacted on staff survey responses due to their potential familiarity with the researcher. One interview was completed by an Assistant Psychologist (IS); most interviews had IS present. The research team regularly reflected on the impact of experiences (including personal ones) and interests during the research process.

Materials

A flexible semi-structured interview schedule (Appendix D) was developed in collaboration with BARA team, guided by the research questions. BARA clinicians suggested creating an easy-read information sheet and communications preferences questionnaire (Appendix E). All materials were reviewed by a neurodivergent Expert by Experience (EbE), leading to amendments, e.g. rewording some questions to enhance clarity.

Two self-reported outcome measures were collected as part of usual care: the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) is a questionnaire covering psychological distress (Evans et al., 2002). The Work and Social Adjustment Scale (WSAS) is a 5-item questionnaire measuring functioning impairment (Mundt et al., 2002).

Participants

Prospective SUs and staff were selected using purposive sampling. Client participants met inclusion criteria if they:

- were diagnosed with autism and/or ADHD, including self-diagnosis given long wait times locally (Oxford Health, 2024; Oxford Health, 2025).
- had experienced some part of the DBT pathway (including on the BPT waitlist, being in or having completed group or individual treatment).

Participants were ineligible if they had insufficient English to complete interview, had moderate/severe learning disability, or were in mental health crisis, defined as being currently open to a crisis resolution team or inpatient stay (1 excluded for this).

Procedure

Clinicians identified eligible SUs open to BPT service. They were contacted by their clinician or by IS, and if willing, the information sheet (and/or easy-read version), consent form, and communication preferences form were sent via email (Appendix E). If SUs consented to participate, communication/access needs were asked about and an interview booked. Microsoft Teams call or in-person appointment were offered: all participants chose the former. Participants were given the option to be accompanied in the interview; however, all chose to interview alone. In the call, participants were informed of the research rationale, given the opportunity to ask questions, and confidentiality policy was explained. They gave verbal consent, with digital consent form signed on their behalf. Demographic information (age, gender, ethnicity, and neurodivergence) was collected. Interviews were video recorded via Teams and stored securely, then anonymised and transcribed verbatim by RQ. Interviews began with the researcher explaining their role; they lasted 18-84 minutes (*M*=41).

PT staff involved at any stage of the DBT pathway were emailed with a Microsoft Forms link inviting them to take part (Appendix F).

Group outcome data were extracted from the clinical notes system Rio, for all individuals who accepted the first and only adapted ECS group, and the most recent three non-adapted groups. This included anyone who had dropped out but excluded those offered the group but who instead requested individual work. For analysis, non-adapted group members were then split into two groups, neurodivergent and neurotypical, ascertained by clinical notes. Reliable change was calculated using the Leeds Reliable Change Index (Morley & Dowzer, 2014), alongside existing research (Lyne et al., 2006). Clinical change was based on a score of below 10 for the CORE-OM and below 20 for the WSAS (Evans et al., 2002; Mundt et al., 2002).

Analysis

Thematic analysis was used to analyse transcripts, using an inductive approach. Six phases of analysis were conducted in an iterative process led by RQ using NVivo and paper (Braun and Clarke, 2006). Data were familiarised through transcription and reading the dataset, with initial codes generated using an open system, then themes were developed, defined, reviewed, and named iteratively; examples of this process are in Appendix G. Independent coding was additionally completed by IS for one transcript; with differences discussed to highlight bias. Final codes were discussed with and shaped by one EbE to ensure accessibility and appropriateness of findings and discussed with research team. RQ kept a reflexive journal.

Due to the small quantitative sample, statistical analysis was not possible; therefore findings were explored descriptively.

Results

Findings included 10 neurodivergent SUs interviews, 11 BPT staff surveys collected February-October 2024, and 42 SUs' quantitative data.

Participant Characteristics

SU demographic information is included in Table 1; all participants were autistic and some had ADHD also. Stage of pathway (including all categories eligible for interview) is included in Figure 1. Staff demographic data was minimally collected to preserve anonymity given team size. Two identified themselves as DBT clinicians (i.e. they provide full-package DBT), whereas nine worked in the wider BPT Team, meaning for DBT clients they were either just involved with assessments, or facilitated the ECS group.

Table 1

Interviewed service user demographic characteristics

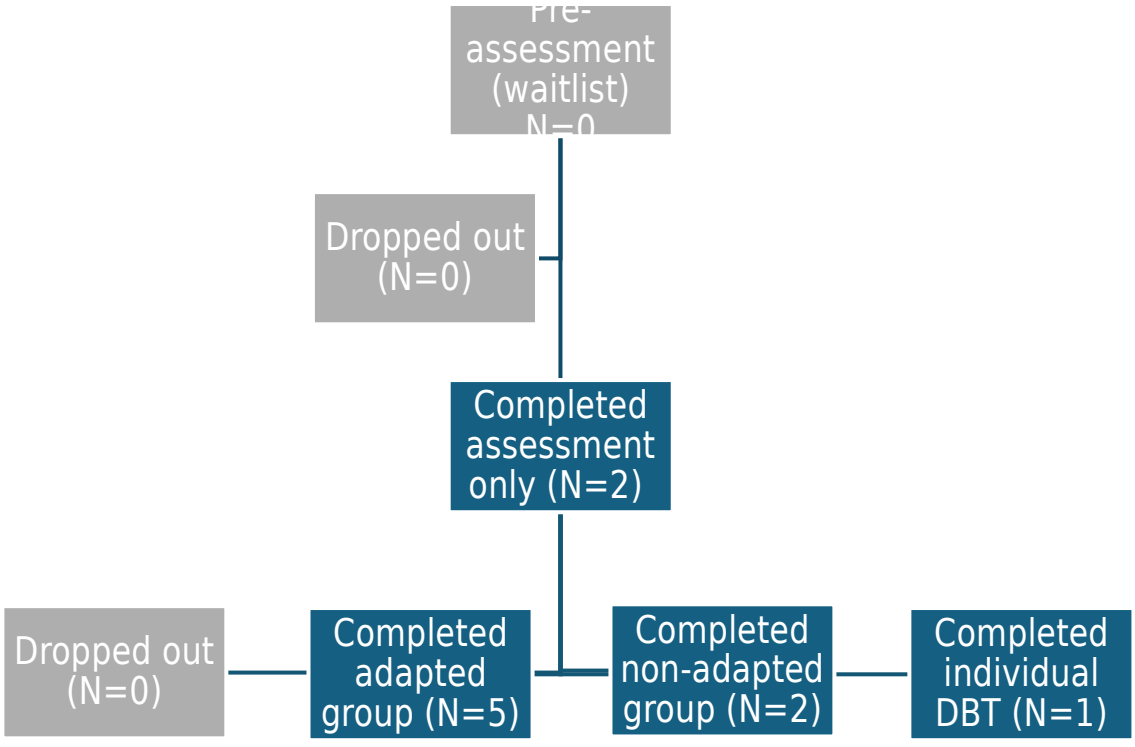
Stage of pathway	Number of participants	Age	Gender	Ethnicity	Neurodivergence
Completed assessment only	2	19-33	Female	Black British, White British	Autism
Completed adapted group	5	20-32	Male, Female, Fluid	White British, Mixed: Asian/White Other	Autism/ADHD
Completed	2	25-30	Female	White British	Autism/ADHD

non-adapted group					
Completed individual DBT	1	19	Female	Mixed: Black/White	Autism/ADHD

Abbreviations: ADHD, Attention Deficit Hyperactivity Disorder

Figure 1

Number of interviewed participants by stage of DBT pathway

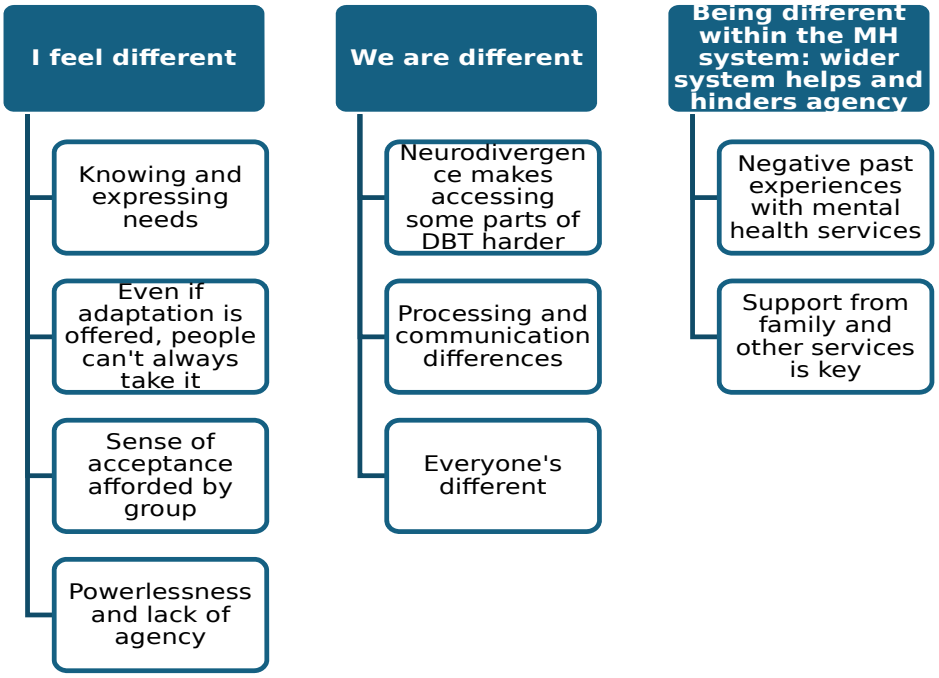


Qualitative findings

Three overarching themes with underlying subthemes were identified, as seen in Figure 2 below.

Figure 2

Service user perspective on experience of BPT



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Themes are described below with supporting quotes, and subthemes included in bold. Additional quotes can be seen in Appendix H.

I Feel Different

The first theme was “I feel different”, capturing the felt sense of not fitting into the standard service offering.

A sub-theme of this was **knowing and expressing needs.** There were differences in how much people felt able to notice and express needs, and to get needs met, within BPT. ES said *“it can be hard to sort of think of, like, my own needs and my own, like,*

struggles until I'm actually in that situation and it's like, oh I'm struggling with this". There was variance in whether people felt they had been asked about adaptations, with one person reflecting that she had *"never been asked like, 'is there anything I can do to make this better for you' or anything?"* and therefore "*I just kinda adapt to the neurotypical conversation style"* (DR). Even within the interview, reflecting on what adaptations could be helpful, many participants said they did not know or remember how they experienced the service.

Some were able to recognise and assert their needs within their BPT assessment: *"I didn't want to be in a group so we declined"* (DR). In contrast, others felt unable to, for instance: *"I didn't actually say or make it clear to the team that I was neurodiverse at first….so that I could have that breather first I guess and see how they react with me*" (OP).

Some participants described a sense of **powerlessness and lack of agency.** CS described feeling forced into DBT:

> *"I didn't really want to go into DBT 'cause I I've done a course of DBT before… I didn't think it helped me as much and I just did say that to them, but they don't really listen, had to do it anyways".*

Others managed to articulate needs in the assessment and were offered adaptations including reduced eye contact and breaks. However, for some **even if adaptation is offered, people can't always take it.** IW described how:

> "…*even if that option is there, I probably would just not take it 'cause I don't want to, like, be a nuisance. So whilst it's nice that that option's there, I'm kind of one of those people that will just plough on regardless"* (IW).

The adapted group stood out as an antidote to this feeling of difference, with the subtheme of a **sense of acceptance afforded by group.** Having a neurodivergent-specific group was well-received, described as "*relatable*" (BM) and *"accepting*" (EC). These benefits were supported by OP, who attended non-adapted ECS group. She "*felt more comfortable when I realised there was someone else in the group who was neurodivergent"* as "*that helped me open up more*", and recommended "*do a group with just neurodivergent people*", as she was unaware the adapted group existed. Although many mentioned the skills as being beneficial, JX added: "*I shared a couple of things that you know weren't particularly in the book or anything but just things I found that helped me……I felt glad that I'd helped somebody, even if it was very minor".*

We Are Different

The second identified theme was "We are different", emphasising the unique needs of both neurodivergent people wholly, and of differences within the conditions.

Some participants highlighted that **neurodivergence makes accessing some parts of DBT harder**. Two (CS and OP) described difficulties with radical acceptance because "*I think so literally…my head flips it...because I think so differently"* (CS). CS described how her therapist facilitated accessibility through adaptation:

> *we had like counters and marbles that we'd use…'cause, I hate ranking things on a scale of 1-10 because I just find it too difficult because I don't know but we'd use how heavy the marbles were instead of a scale of 1-10*

Some elements of DBT were described as helpful for autism-specific emotion regulation difficulties: "*it helped me work out what I need to like work out why I'm*

going into meltdowns, I've had discussions 'bout why I go into meltdowns because mine are very strong, I'm emotion-controlled mind I'm not wise mind" (KF).

Most participants described **processing differences** impacting on assessment and therapy, including "*information overload*" (KF, OP) and it *"takes me longer to learn*" (KF). Some participants had their own ways of coping with these difficulties. Three mentioned stimming/fidgeting (IW, ES and DR). Two from the adapted group looked at the group material ahead of time to prepare (IW and KF), though KF described it as difficult to follow when *"we was following the book and then we jumped off the book".* Participants liked therapist adaptations: four mentioned liking the videos and visual materials provided, with one person citing the helpfulness of content repetition: *"the DEARMAN thing I think I learned that because it went over it like 3 times or something" (KG)*.

Reminders were appreciated; the non-adapted group's reminder system was less robust and the need for this was clear from ES, who described: "*I missed the first two sessions because I forgot it was happening".* The adapted group facilitator's reminder phone calls a few minutes into sessions was seen as helpful: *"I think they were quite good because very often [Assistant Psychologist] would phone up and remind people and stuff because of course a lot of people who are neurodivergent struggle with schedules"* (JX).

Communication differences were a further factor impacting engagement. OP said:

> *I just tried to have, like a kind of like a script, sort of what I just wanted to say, and so then having that script get broken in a way by that question coming in is what then made it difficult….to then have that broken, kind of threw me off*

> *to then, which I ended up just giving an answer like giving answers that even I didn't understand and maybe didn't even mean.*

This illustrates how assessment and therapy, often responsive to what a SU brings, can be challenging for neurodivergent individuals due to communication strategies they have developed.

Clients reflected on the benefits of being able to access online therapy (which most participants had done) for neurodivergent individuals. Online was praised by 6 participants, allowing the person to be in "*my own safe space"* (IW) and being "*comfortable*" (BM). However, a minority felt "*online is difficult*" (CS).

Neurodivergent people, although often needing similar adaptations, are of course a non-homogenous group: **everyone's different**. ES described this sentiment: "*for someone else whose autism affects them differently than me, this group could be really helpful, having something very structured…it's not a one-size-fits-all kind of thing".*

Being different within the mental health system (wider system helps and hinders agency)

The final theme relates to participants not accessing BPT in a vacuum: they brought both current and past experiences with the wider system. **Negative past experiences with services** affected their ability to engage with BPT. OP did not share her neurodivergence initially, having worries that *"I'm too serious for the team and that they'd have to refer me to somebody else"* due to feeling *"judged"* in the past. She described feeling "*really comfortable with my assessor and she really helped, you know, make me feel comfortable so that I was able to open up about*

myself more", due to adaptations such as allowing enough time: *"I could be rambling on for ages and they wouldn't tell me, you know, like to shut up".*

Support from family and other services is key, and was mentioned by half the participants, including siblings (IW), mothers (DR, OP), mental health nurse (KG), and support workers (KF). Support from others helped their understanding of material "*if I don't understand something, I'll show someone else it like my support workers and they can tell me what it was* (KF), and aided organisation *"managing quite a lot of my bookings"* (IW). KG's mental health nurse emailed BPT when he repeatedly struggled with technical difficulties; he reflected on how this could disadvantage those without support:

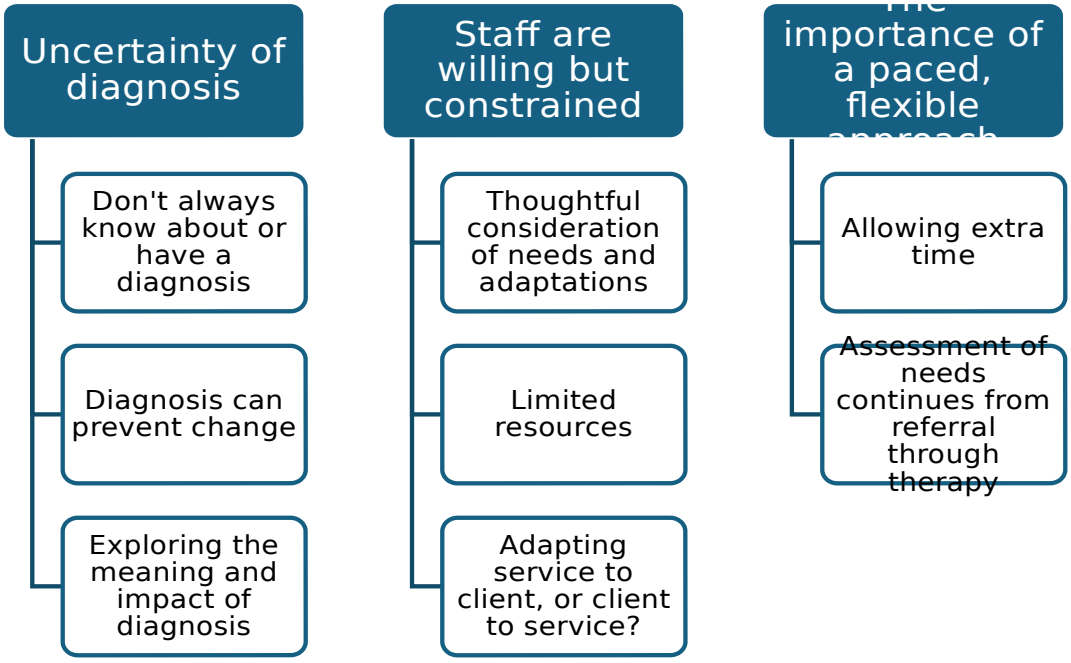
> RQ: *It sounds like it was helpful to speak to your mental health nurse as well when things weren't going so well.*
>
> KG: *Yeah, but not everyone has a mental health nurse.*

Staff survey themes

Three overarching themes from the staff survey with underlying subthemes were identified. Themes from the staff survey are described and presented below (Figure 3). Additional quotes are in Appendix I.

Figure 3

Staff perspective on neurodivergent service user experience of BPT



Uncertainty of diagnosis

Staff noted they **don't always know about, or clients don't always have, a diagnosis** of neurodivergence. P6 described "*lack of confirmation if a patient has a diagnosis of ADHD and/or autism*" as a barrier. P5 shared how they:

> *considered in supervision when and how it might be appropriate/suitable to consider if neurodivergence...or the client has described difficulties which might be understood in the context of neurodivergence.*

The importance of **exploring the meaning and impact of diagnosis** was the third subtheme, discussed by four. P2 rhetorically asked: "*What impact has it had on their*

life and day to day? And what does it all mean to the patient?". Others spoke about how a neurodivergence **diagnosis can impede change**; P2 argued *"it can be overused as an area of validation and identity so hard for the person to see change as possible".*

Staff are willing but constrained

Staff had **thoughtful consideration of needs and adaptations**. P7 highlighted various communication, organisation, and information processing adaptations: "*having easy reads, adapting diary cards, adapting chains within sessions, writing more notes for the patient".* Despite intention to adapt, **limited resources** prevented full adaptations, with three participants focusing on environment. P7 gave an example of "*One of my patients wanted a room with a window, better lighting, lights etc, there were issues in terms of booking a suitable room when I enquired there was no room availability which makes it hard."*

Staff opinion diverged as to **whether to adapt the service to the client, or the client to the service.** One therapist spoke about how they would "*ask the team for more sessions for clients if needed*", whereas two others primarily considered how much a client could get from the existing service: "*set realistic goals for therapy, considering limited session numbers*" (P9).

The importance of a paced, flexible approach

Consideration of timings and flexibly responding to clients' needs were highlighted as important. **Allowing time** was raised by nine clinicians, with P4 highlighting that "*within DBT pre-treatment we have an extended assessment which is helpful".*

Adaptations were not a one-off question: **ongoing assessment from referral through therapy** was used to support clients to access service. P5 described how adaptations can begin before the assessment *"where we have been advised in referral of neurodivergence, where this is known, I would ask if there is anything I can be aware of to make any reasonable adjustments*". P4 further said "keep coming back to what is working well/not well*",* illustrating continued checking of needs*.*

Quantitative findings

Quantitative data were collected to provide a group attendance overview for all who accepted the group intervention (Table 2). This included number of sessions attended, drop-outs, and CORE-OM outcome measures for three samples: neurotypical non-adapted ECS group (N=20), neurodivergent non-adapted group (N=14), and neurodivergent adapted group (N=11). Notwithstanding sample size, the data indicate that drop-out rates were higher for neurodivergent SUs versus neurotypical, and attendance was lower, supporting anecdotal staff observations. There was minimal difference in non-adapted versus adapted group drop-out rates (57% vs 55% respectively) and between sessions attended percentage, though notably session numbers were higher for the adapted group (33) than the non-adapted group (14-17, depending on the group).

Table 2

Attendance and drop-out rates for groups

	Neurotypical clients in standard group (N=20)	**Neurodivergent clients in standard group (N=14)**	**Neurodivergent clients in adapted group (N=11)**
Drop-out percentage	35%	57%	55%
Average percentage of sessions attended	66% (of 14 or 17 sessions)	55% (of 14 or 17 sessions)	49% (of 33 sessions)

Review of outcome measures was attempted for the 42 group participants. 23 individuals had completed the pre-group outcome measures, with CORE-OM mean score of 22 (*R*=12-34) and WSAS mean score of 24 (*R*=10-40), indicating moderately severe psychological distress, and impairment, respectively.

Baseline outcome measures were completed by 23 of the 42 SUs. A summary of these baseline scores, broken down by group, is provided in Table 3. Data indicate that all three groups presented with moderately severe psychological distress on the CORE-OM, though there was a notable difference in functional impairment, with neurotypical clients reporting moderately severe impairment on the WSAS, whereas both neurodivergent groups reported on average severe functional impairment before starting therapy.

Table 3

Baseline Outcome Measures

Group	Measure	Range	Mean (SD)	Clinical Severity
Neurotypical clients in standard group (N = 11)	CORE-OM	12-32	20.6 (5.63)	Moderately severe
	WSAS	10-35	21.5 (7.27)	Moderately severe
Neurodivergent clients in adapted group (N = 9)	CORE-OM	14-28	24.2 (4.85)	Moderately severe
	WSAS	10-35	29.8 (7.52)	Severe
Neurodivergent clients in non-adapted group (N = 3)	CORE-OM	14-34	22.3 (8.5)	Moderately severe
	WSAS	20-38	27 (7.87)	Severe

Abbreviations: CORE-OM, Clinical Outcomes in Routine Evaluation – Outcome Measure; WSAS, Work and Social Adjustment Scale.

Only three individuals (all adapted group attendees) completed both pre- and post-measures, limiting inferences from the results. Two were in the severe range and one was in the moderate severe range on the CORE-OM. All CORE-OM scores reduced post-group (Table 4), though no SU met clinical change threshold, and only one SU met reliable change threshold.

Table 4

Outcome measures pre- and post- group

	Service User 1	Service User 2	Service User 3
CORE-OM			
Pre-Score	24	27	28
Post-Score	13	23	26
Change	-11	-4	-2
Reliable Change?	Yes	No	No
Clinical Change?	No	No	No
WSAS			
Pre-Score	34	40	40
Post-Score	29	34	40
Change	-5	-6	0
Reliable Change?	Yes	Yes	No
Clinical Change?	No	No	No

Discussion

This study aimed to understand the experience of neurodivergent individuals accessing the DBT pathway within BPT. Findings suggest that adapting a service for neurodivergent people is a nuanced endeavour. It is not as simple as providing a uniform set of adaptations.

A prominent finding among SUs was the pervasive *felt sense of difference* within the service, and of not fitting into the standard service offer, a common experience for neurodivergent individuals navigating neurotypical systems (Mansour et al., 2025). Research typically has focused on how services do not meet neurodivergent people's needs; however, these findings emphasise an important complexity. Neurodivergent people, used to living in a neurotypical world, find it challenging to

know what they need, ask for it, or even accept it when offered, likely shaped by this sense of being different, and by negative past experiences. Some staff had an awareness of needs articulation difficulties, expressing a commitment to continued checking in. This situation requires a delicate balance. The *powerlessness and lack of agency* described by SUs, exemplified by feeling pressured into therapy, highlights a risk. If SUs struggle to articulate needs, the onus falls on staff to identify and offer adaptations. Bertilsdotter Rosqvist et al. (2023) highlight how neurodivergent individuals can learn what they need through receiving helpful support. While crucial, there is a risk for staff to inadvertently override SU autonomy and needs, especially within an NHS context facing *limited resources* or differing views on where the line is between *adapt the service to the client, or the client to the service*. Family and other services were instrumental in successful access for some, highlighting a potential disadvantage for those without such external support. BPT should consider whether additional support may be required for those without, to facilitate equitable engagement. Overall, this underlines the importance of *a flexible and curious approach*, and a conscious effort to reduce power while effectively scaffolding SUs to identify and accept helpful adaptations.

Qualitatively, the adapted group emerged as a powerful antidote to the felt sense of difference, for some. The group fostered an atmosphere of acceptance, and members were able to share coping strategies. Interestingly, the quantitative data, while limited due to small sample size, indicates that despite the sense of belonging, the group dropout was largely similar between adapted and non-adapted groups. This may be explained by all interviewees being group-completers. The elevated dropout rates among neurodivergent SUs present a dilemma: while decreased engagement is considered desirable, this may be driven by neuronormative priorities

(Tillett, 2023). An overemphasis on attendance risks promoting masking, and harm through normative conformity. This is complicated by the need for consistent repetition and exposure in skills-based DBT, which is crucial for learning given processing and communication differences, underlined by the qualitative findings.

The theme ‘we are different’ more practically highlighted the *processing and communication differences* of neurodivergent individuals accessing DBT, supported by literature (Howard & Sedgewick, 2021). Staff and SU findings converged, with staff particularly emphasising the importance of *allowing more time*. A notable divergence was that staff placed heavier emphasis on the sensory aspects; this may be explained by most of the SUs accessing therapy online, therefore may have been more able to manage their sensory needs in their own safe space.

Challenges in outcome measures were significant, limiting definitive conclusions on clinical change. Difficulties in completing outcome measures may stem from scales being more challenging for neurodivergent people, as identified in the qualitative findings, and there are few measures validated for autistic people (Schiltz et al., 2024). For the few participants who completed paired measures (all from the adapted group), slight improvements were observed, though completion of outcome measures perhaps reflected increased baseline motivation. BPT need to explore outcome measure completion barriers and develop more accessible feedback methods, accommodating neurodivergent communication styles. The high rate of missing data suggests that the current approach is not sufficiently accessible for neurodivergent individuals, though the adapted group had more success in collecting these measures. The service is encouraged to work on enhancing collection methods, which could include collaboratively working with service users to understand the barriers and find ways to address these. They may consider adapting

existing measures or data collection methods, for instance offering multi-model options, and providing dedicated time and support.

The findings have clear clinical implications. Staff should remain flexible and curious, considering ways to reduce power allowing SUs to voice their needs and accept the adaptations offered. More consistent use should be made of adaptations such as extra processing time and additional resources such as handouts and reminders, with regular checking that adaptations are appropriate to the SU. Some SUs described not always knowing what they need, and staff described supporting this through continued exploration. Both SUs and staff reflected on the impact of the wider system, with SUs noting both the impact of past negative experiences and the current benefits of wider family and service support, and staff highlighting the impact of working with limited resources.

The DBT team found the SIP findings thought-provoking, prompting further reflection on commonly difficult aspects of DBT they have noticed. They highlighted that offering adaptations would likely be helpful for all SUs, including neurotypical individuals, which may be particularly helpful given SUs didn’t always know or express what they need, staff didn’t always know about a client’s neurodivergence, and given long assessment waiting times. The adapted ECS group will continue, and the team plans to continue reflection on this during their next Team Away Day, involving co-production.

Limitations

The sample was skewed towards ECS-group completers; thus, findings are richer on this compared with individual-DBT. Service barriers may have been inadvertently replicated: SU participants were required to attend an interview, and communications

preferences form was not typically completed, therefore adaptations could not then be planned. Interviewed participants may have been inherently more engaged and found services met their needs. Further research into the dropout rates would also be beneficial, perhaps looking at group differences between drop-outs vs attenders, given the difficulties in reaching this group.

The study focuses on autism/ADHD. While this may strengthen the pragmatic utility of the findings given the adapted group entry requirements, the two groups' needs can diverge extensively. Grouping them risks losing nuance. All interviewees were autistic, with three also having ADHD, which may reflect staffs' perception of neurodivergence, and limit applicability to individuals with ADHD only.

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Theory Driven Research Project: Social Identity, Identity Integration, and Wellbeing in Voice Hearers: An Experimental Investigation

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Abstract

Background: Integrating a voice hearer identity with other important social identities to form a positive, coherent sense of self is associated with better wellbeing for people who hear voices. There are increasing lived experience narratives shared online in video format about the voice hearing experience, though it is unclear whether videos like this foster increased social identity integration for viewers.

Method: In this study, we compared the impact of watching lived experience stories featuring the integration of a voice hearer social identity, with a control video, on variables of identification, identity integration, and wellbeing.

Ninety-four people who self-identified as hearing voices completed an online survey, completing baseline and state measures including social identity, identity integration, and wellbeing. Participants were then randomised to watch one of two videos, (a) a co-produced, 8-minute video-based intervention, featuring three actors describing their experience of integrating their voice hearer identity into their wider sense of self, or (b) a control video about the weather. Participants completed post-intervention measurements of state social identity, identity integration, and wellbeing. ANOVAs and linear regression were used to analyse data.

Results: There was no significant effect of the lived-experience narrative video on voice hearer identity integration, nor was identity integration found to predict change in wellbeing or post-intervention wellbeing scores. However exploratory analyses showed a significant group by time interaction for identity, suggesting that identification as a voice hearer may have been enhanced by the video intervention.

Conclusion: The lack of significant findings regarding identity integration may reflect the brief nature of the intervention, or the complexity of social identity integration

processes among voice hearers. Further exploration of identity-related mechanisms in voice hearers is warranted; future research could consider more intensive interventions and explore individual differences.

Keywords: Hearing Voices, Social Identity, Identity Integration

Introduction

Hearing Voices

Auditory verbal hallucinations, also known as hearing voices, are subjective perceptions of speech that occur in the absence of corresponding external stimulus, seemingly real to the voice hearer (Tracy & Shergill, 2013). A previous meta-analysis found a mean lifetime general population auditory hallucination prevalence rate of 9.6% (Maijer et al., 2018); these experiences can have deleterious emotional and social impacts on the individual (Rammou et al., 2023). Hearing voices is not always an indication of psychopathology and despite common preconceptions, does not necessarily lead to distress (Baumeister et al., 2017).

Although a relatively common experience, many voice hearers experience stigma, often feeling that non-voice hearers do not understand or accept their experiences (Corstens et al., 2014). For those diagnosed with a mental health condition, stigma related to this can result in greater negative impacts than the condition itself (Thornicroft et al., 2016). For example, stigma may increase isolation and distress by preventing individuals from disclosing their voices to those around them (Vilhauer, 2017). Romme and Escher (1989) found that the way an individual appraises their voices can impact the distress the voices cause, which paved the way for the Hearing Voices Movement. This movement aims to challenge this stigma by normalising the voice hearing experience (Corstens et al., 2014). Research has also shown that although experiencing psychosis (including hearing voices) can be traumatic, many individuals encounter post-traumatic growth during recovery, involving positive experiences of self-discovery, improved well-being, valued relationships, and spirituality (Jordan et al., 2017; Slade et al., 2019).

Social Identity Theory

Social Identity Theory posits that people define their own identities in relation to social groups; these identifications help protect and bolster self-identity (Tajfel, 1979). Indeed, group identification benefits health and wellbeing, and one's subjective sense of belonging, even when social contact is controlled for (Sani et al., 2012). However, for those with mental health conditions, group identity has been found to have both positive and negative implications for self-esteem (Crabtree et al., 2010). For example, Cruwys & Gunaseelan (2016) found that for those with depression, group membership can magnify the negative relationship between stigma and well-being. This suggests that when stigma is at play, as often is the case with voice hearers, the relationship between group identity and wellbeing may be a more complex one. Further, individuals can have multiple identities, flexibly activated based on situational cues or motivational factors (Hirsh & Kang, 2016). Conflict can arise when these multiple identities feel incompatible, leading to distress (Hirsh & Kang, 2016).

Social Identity Integration

Social identity theorists have explored how new identities can be incorporated into one's overarching self-concept. The Cognitive-Developmental Model of Social Identity Integration (CDMSII) posits four stages: Anticipatory Categorisation, Categorisation, Compartmentalisation, and Integration (Amiot et al., 2007). The final stage, social identity integration, refers to how various self-components are organised structurally within the self, allowing multiple identities to be simultaneously important to the overall self-concept (Amiot et al., 2007). Integration has been shown

to be important in increasing wellbeing in individuals who hear voices and therefore may be an important target for treatment (Hogg et al., 2023).

Research on factors that facilitate and encourage social identity integration within voice hearers is limited, with existing integration literature often focusing on bicultural integration (Spiegler et al., 2022). Whilst not precisely equating to identity integration, literature on recovery, and factors enabling and inhibiting disclosure of mental health difficulties, may offer insight into factors that impact identity integration. For example, factors like fear of stigmatisation and misunderstanding of symptoms can prevent disclosure, thus confronting negative perceptions can enable disclosure (Bogen-Johnston et al., 2019). Remaining cautious about disclosure and only sharing with trusted others is important for voice hearers in recovery, even after having positive experiences of disclosure and connecting with others (De Jager et al., 2016). Literature on Hearing Voices Network Groups identifies elements such as instillation of hope and learning from others as beneficial aspects of these groups (Corentin et al., 2023; Longden, 2017).

Use of Media

People who have unusual experiences often search online for mental health content, looking for first-person perspectives (Aref-Adib et al., 2020). Digital media and technology are increasingly used to facilitate interventions (Menon et al., 2018). Interventions have included videos of individuals with lived experience to present information engagingly, with stories of hope and recovery being particularly valued (Honary et al., 2018). Amsalem and colleagues have conducted a range of studies looking at reducing psychosis self-stigma through brief video-based interventions, showing these can reduce stigma and show sustained impact (Amsalem et al.,

2021). There are no known studies exploring video interventions aimed at targeting identity integration.

Aims and hypotheses

The primary aim of the study was to establish whether a brief video intervention of people describing experiences of voice hearer social identity integration affected:

a) Integration of a voice hearer social identity
b) Well-being

Based on the primary aim, we developed two hypotheses:

H1: Compared with a control video condition, the video intervention will lead to greater integration of a voice hearer social identity.

H2: The extent of voice hearer social identity integration will predict change in wellbeing over time (pre- and post-intervention).

A secondary aim of the study was to explore whether social identification, paranoia, and voice hearing history confounded the impact of the video intervention.

Method

Study Design

This study followed a randomised controlled experimental study design. Participants were randomly assigned to either the intervention group or the control group, stratified by age and gender using Qualtrics logic, to ensure a roughly even split of these demographics. Participants all completed baseline measures, then watched one of the two videos before completing post-video measures.

Intervention

We compared the effect of a brief intervention video. The intervention video presented three individuals (actors) describing their experience of voice-hearer identity integration, covering themes of telling people around them about their voice hearing experience, how they define their experiences, and the impact of hearing voices on their everyday life.

Video Development Process

The video was developed over the course of 9 months. To inform video scripts, three experts with lived experience of hearing voices (Experts by Experience; EbE) were interviewed, to explore the important features of the video (including length, style, and content). Following this, EbE who were willing to share their stories were interviewed with the purpose of developing a script based on their experiences. Interviews aimed to elicit the key facilitators of identity integration (e.g. coping, adaption, and social support) alongside capturing ways that inhibitors were overcome, such as feelings of threat (Amiot et al., 2007). RQ developed anonymised scripts, with individuals reviewing scripts for accuracy, leading to changes e.g. the inclusion of family support. Other EbE also reviewed the scripts to provide external feedback on how well the scripts captured the concept of identity integration in relation to voice hearers. The final scripts and video link are in Appendix B. Once finalised, three actors, who all had professional and/or personal experience with other people who hear voices, were filmed reading the scripts. Actors were used to protect EbE from any unanticipated negative consequences of online exposure, a decision advised by other EbE and confirmed by those who shared their story. Actors have been shown to be as effective as experts by experience in mental health

intervention videos (Amsalem et al., 2024). Recordings were edited using Adobe Premiere Pro, with drafts sent to three EbE to review and suggest changes. Numerous changes were consequently made, including stylistic changes and editing the videos to be split up rather than to be in blocks (i.e. the video jumped between the three individuals, rather than each person speaking uninterrupted), to aid engagement.

The control video was filmed with two of the same actors and one different actor (due to availability), reading scripts on nature and the weather, similar to Brown et al. (2020). The intervention video was 8 minutes 13 seconds long. Initially the control video was the same length, but EbE recommended shortening it to maintain engagement, therefore it was 6 minutes 40 seconds long. The final video was uploaded as an unlisted video on YouTube to be embedded into Qualtrics.

Sampling Procedures

Data collection took place from November 2024 - May 2025 using an anonymised online survey held on Qualtrics XM Platform™ (Provo, UT). Participants were invited to contribute voluntarily via social media and charities (research poster and participant demographics are in Appendix C). Participants were given the option of completing the study on MS Teams, to improve access, or independently online. A debrief page was included at the end of the study on Qualtrics (Appendix D) signposting participants to sources of support if they were negatively affected by participating. The project received ethical approval from the University of Oxford Central University Research Ethics Committee (Reference R94296/RE001; Appendix E).

Participants

Participants were eligible if they (1) self-identified as hearing voices that other people do not, (2) were aged 18+, (3) lived in UK/Republic of Ireland. Exclusion criteria were (1) having a moderate/severe learning disability, (2) insufficient English to complete the study, and (3) not feeling well enough to participate.

In the absence of previous work on video interventions for identity integration, we sought a small effect size. A priori power analysis using G* Power software (Faul et al., 2007) indicated a sample size of 90 was required based on a Cohen's *f* effect size of 0.15 with α = 0.05 and 80% power.

Measures

Demographic information was collected including age, gender, ethnicity, education level, and working status. Age was collected in groupings (e.g. 18-25 years old) to reduce anonymity concerns. Information on mental health diagnoses, age voices were first heard, previous mental health-related admission, and previous mental health input were collected to provide context. Measures are included in Table 1 and Appendix F.

Table 1

Measures

Concept measured	**Measure used**	**Information**	**Validity and reliability**
Paranoia	State adapted Paranoia Checklist, Brief version	5-item questionnaire (e.g. 'I need to be on my guard against others'); 11-point Likert scale from 0 (not at all) to 10 (very much). The sum of all items produces a total score.	Shown to be valid and reliable (Schlier et al., 2016).
Voice	Hamilton Program	9-item measure (e.g., 'how bad	This measure has

Hearing Severity	for Schizophrenia Voices Questionnaire (HPSVQ; Van Lieshout & Goldberg, 2007)	are the things the voices say to you?'), with 5-point Likert scale from 0 (least severe) to 4 (most severe). The items cover frequency, distress, volume, negative content, duration, interference in life, clarity, impact on self-appraisal, and compliance with demands. It was developed based on the auditory hallucinations part of the Psychotic Symptom Rating Scales (PSYRATS-AH; Haddock et al., 1999)	good construct validity and reliability (Van Lieshout & Goldberg, 2007; Kim et al., 2010)
Baseline Voice Hearer Identity	Adapted in-group identification scale, adapted in line with Hogg et al. (2023), based on existing scale by Leach et al. (2008)	Visual analogue 7-item scale (e.g. 'I identify with voice hearers'), with 1 being fully disagree and 7 being fully agree.	This measure has good internal consistency, construct, predictive and discriminant validity (Leach et al., 2008).
State Voice Hearer Identity	Single item Social Identification Measure (Postmes et al., 2013)	Single item visual analogue scale 'I identify with voice hearers' on 1-7 scale, with 1 being fully disagree and 7 being fully agree. State identity was used for all pre-post analyses.	This measure has been found to be valid and to have good reliability across a broad range of social groups (Postmes et al., 2013)

Baseline Voice Hearer Identity Integration	Multicultural In-Group Identification Scale (MULTIIS; Yampolsky et al., 2016)*;* integration subscale only	8-item measure with items such as ‘My voice hearer identity and my other identities are connected’ on 1 (not at all) - 7 (exactly) Likert scale	This measure has good internal consistency, and convergent and predictive validity (Yampolsky et al., 2016)
State Voice Hearer Identity Integration	Continuous Inclusion of Other in the Self scale (Beranek & Castillo, 2024), based on Aron et al. (1992)	A single item pictorial measure with 11-point scale, with ‘my overall identity’ on one circle and ‘my voice hearer identity’ on the other. Javascript code for measure was sourced from GitHub (Castillo & Beranek, 2024); then added to Qualtrics.	Inclusion of Other in the Self scale has been repeatedly validated (Gächter et al., 2015)
State wellbeing	Short Warwick-Edinburgh Mental Wellbeing Scale (Stewart-Brown et al., 2009), adapted	7-item measure with 5-point Likert scale (0 = none of the time, 4 = all of the time), adapted to be present focused e.g. ‘I've been feeling relaxed’ was changed to ‘I feel relaxed’.	Found to be valid and reliable for service users (Vaingankar et al., 2017)
Video engagement level	Visual analogue scale	Single item ‘how engaging did you find the video?’; scale 0-100; not at all engaging – very engaging	Created for study
Level of video resonance	Visual analogue scale	Single item ‘how much did the video resonate with/feel relevant to you? scale 0-100; not at all – very much so	Created for study

Data Diagnostics and Analysis

Following data collection, checking for missing values and repetitive responding was completed (none found) to determine the final sample. Composite scores for measures were calculated according to scoring guidelines.

Data preparation and all analyses were conducted using jamovi 2.6.26 (including GAMLj module). T-tests and chi-squared tests were conducted for main demographic variables and questionnaire scores between groups. Fisher's Exact test was used for testing differences between groups where demographics had small cell size. Some variables were re-coded for testing due to low frequencies in some categories, e.g. within ethnicity, categories were collapsed into 'white' and other ethnic background' and age groups were collapsed into broader categories, to allow for valid statistical comparison. Data were analysed using a combination of mixed-effects ANOVAs and linear regression to assess the impact of the intervention on voice hearer identity integration, and to test predictive relationships.

Results

Sample Characteristics

From the start of recruitment, 329 people entered the Qualtrics survey, with 94 people completing the survey. The highest percentage came from Facebook (47.9%). Two participants completed the study with the researcher via MS Teams due to accessibility difficulties; the rest completed it independently. Prior to analysis, no samples were excluded for missing key variable data and there were no responses that were clearly repetitive (e.g. all responses were the same number on a measure). Data from 94 participants were included in the analysis, with demographics detailed in Table 2, measures in Table 3, pre-and post-scores in Table 4, and further demographics in Appendix G Fifty-five were female (58.5%), 27 male, seven transgender, and five non-binary. The youngest age demographic was 18-24-years-old and the oldest was 85 and over, with the highest proportion being aged 18-

24. Most respondents were White British (71.3%). Forty-eight participants (51.1%) were shown the intervention video; and 46 (48.9%) the control video.

Table 2

Participant demographic characteristics

Measure	Intervention sample (N=48)	Control sample (N=46)	Test (df)	p-value
Gender			Fisher's Exact	0.586
Female	26 (54.2%)	29 (63%)		
Male	14 (29.2%)	13 (28.3%)		
Transgender	4 (8.3%)	3 (6.5%)		
Non-binary	4 (8.3%)	1 (2.2%)		
Age			$\chi^2(4) = 1.54$	0.820
18-24	12 (25%)	11 (23.9%)		
25-34	9 (18.8%)	9 (19.6%)		
35-44	9 (18.8%)	5 (10.9%)		
45-54	8 (16.7%)	8 (17.4%)		
55 and over	10 (20.83%)	13 (28.3%)		
Ethnicity			Fisher's Exact = 1.0	0.738
White (any)	44 (91.7%)	43 (93.5%)		
Other ethnic background	4 (8.3%)	3 (6.5%)		

Table 3

Baseline descriptive measures between experimental groups

Measure	Intervention sample (N=48) *M (SD)*	Control sample (N=46) *M (SD)*	Test (df)	p-value
State Brief Paranoia	25.5 *(13.11)*	21.4 *(14.2)*	-1.448 (92)	0.151

Checklist				
HPSVQ	17.4 *(7.37)*	16.5 *(7.79)*	-0.573 (92)	0.568
In-group Identification Scale, adapted	41.7 *(16.67)*	43.5 *(18.08)*	0.505 (92)	0.615
MULTIIS, adapted	22.9 *(10.53)*	24.7 *(11.46)*	0.812 (92)	0.419
SWEMWBS	18.6 *(4.7)*	19.8 *(5.71)*	1.134 (92)	0.260
Video Engagement rating	55.6 *(31.7)*	38.8 *(30.4)*	-2.62 (92)	0.010*
Video resonance rating	56.9 *(32.2)*	38.4 *(32.8)*	-2.76 (92)	0.007*

Abbreviations: HPSVQ, Hamilton Program for Schizophrenia Voices Questionnaire; MULTIIS, **Multicultural In-Group Identification Scale**; SWEMWBS, **Short Warwick-Edinburgh Mental Wellbeing Scale**.

*Scores significantly differed at 0.01 level

To better situate the clinical characteristics of the sample, baseline scores were compared with established ranges for the measures used. For the HPSVQ, the mean scores of 17.4 and 16.5 for the intervention and control group respectively. Scores between 14-25 indicate moderate severity of auditory hallucinations (Behilak et al., 2020). Both group scores fell within this range, suggesting that the sample on average was composed of individuals who were experiencing a moderate level of voice hearing at the time of the study. Voice hearing severity within this study was lower than scores in a similar sample (Hogg et al., 2023).

The Brief Paranoia Checklist does not have pre-defined cut-offs, however a sample of general population individuals with high levels of non-clinical paranoia were found to score 24.04 on this measure (Sood et al., 2021). This score is close to the mean

scores of 25.5 (intervention) and 21.4 (control) found in the current study. Scores of paranoia were lower than scores found in a similar study (Hogg et al., 2023).

The SWEMWBS does not have pre-defined clinical cut-offs. In one sample of people with schizophrenia, the mean score was 22.8, which is higher than that of this study's sample (Vaingankar et al., 2017).

The visual analogue scales for identity and identity integration were adapted, and the original scales do not provide cut-off scores. However, mean pre-scores for both state identity and state identity integration were roughly half of the total possible score, with mean state identity scores being 3.78 and 3.33 for control and intervention group respectively, out of 7, and mean identity integration scores being 5.3 and 5.81 for control and intervention group respectively, out of 11.

Table 4

Pre- and post-video state measures

State Measure	Group	N	Mean	Median	SD
State Identity Integration (pre)	Control	46	5.30	5.00	3.31
	Intervention	48	5.81	5.00	3.25
State Identity Integration (post)	Control	46	5.48	5.00	3.36
	Intervention	48	6.02	6.00	3.43
State Identity (pre)	Control	46	3.78	4.00	1.98
	Intervention	48	3.33	3.00	1.96
State Identity (post)	Control	46	3.65	3.50	1.96
	Intervention	48	4.13	4.00	2.10
State wellbeing (pre)	Control	46	19.83	20.00	5.71
	Intervention	48	18.60	19.00	4.70

State wellbeing (post)	Control	46	19.98	20.50	5.92
	Intervention	48	19.29	19.00	4.83

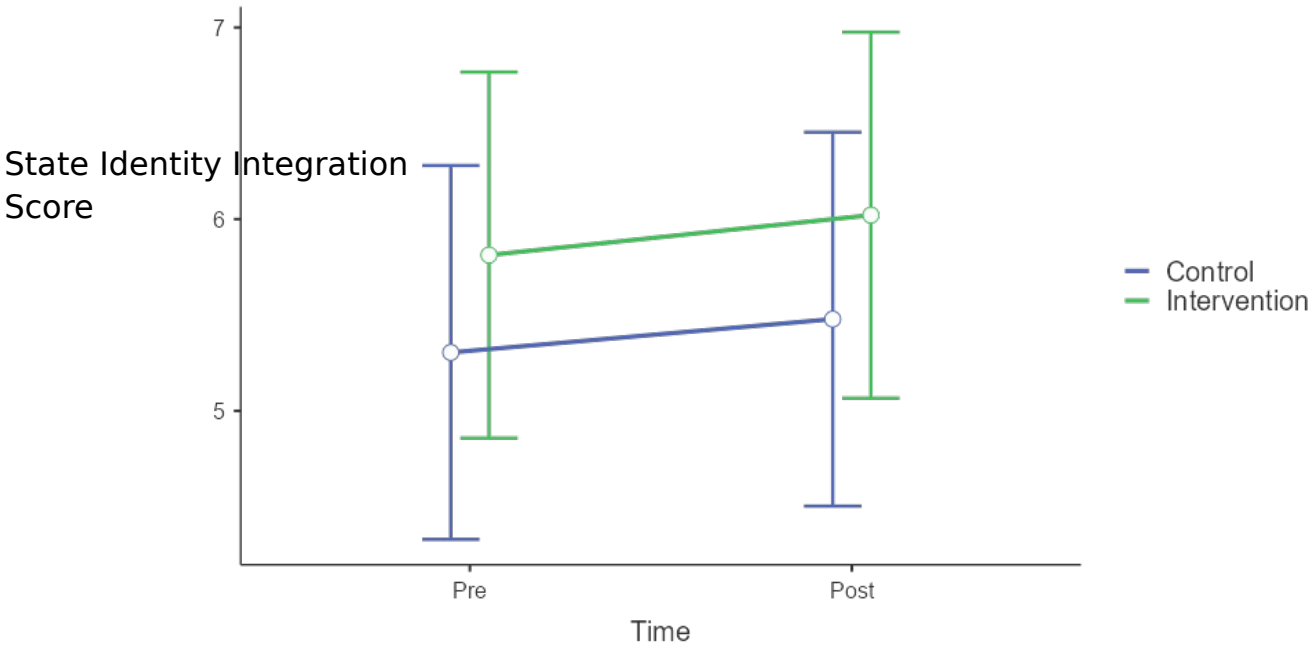
Hypothesis One

A two (Group: intervention, control) x two (Time: pre, post) mixed ANOVA was conducted using the GAMLj module in jamovi with state integration of voice hearer social identity as a dependent variable. Prior to analysis, residual assumptions were assessed. The Shapiro-Wilk test indicated a violation of normality ($p < 0.001$) and although there was approximate linearity in the Q-Q plots, there was deviation in the tails (see Appendix H). Due to this, ANOVA results were supplemented with bootstrapped analyses with 10,000 samples to obtain robust estimates of significance.

The group time interaction was not significant $F(1, 92) = 0.008$, $p = 0.930$, suggesting that change in state voice hearer social identity integration scores over time did not differ between groups. There was a bootstrapped estimate of -0.03 and a 95% confidence interval of [-0.82, 0.76], with the inclusion of zero supporting no reliable difference in change over time between groups: results can be seen in Figure 1. These results do not support the hypothesis that the intervention increased integration of a voice hearer social identity more than the control condition.

Figure 1

Social identity integration change, pre- and post-intervention across groups



Visual Inspection and Subgroup Analysis

Spaghetti plots of individual state integration scores from pre- to post-intervention are in Figure 2. Individuals were split into subgroups based on their state integration change score (post-score minus pre-score), according to whether their integration score increased (“increasers”), stayed the same (“no-change”), or decreased (“decreasers”). Numbers of each category can be seen in Table 5.

Figure 2

Individual State Integration Change Scores

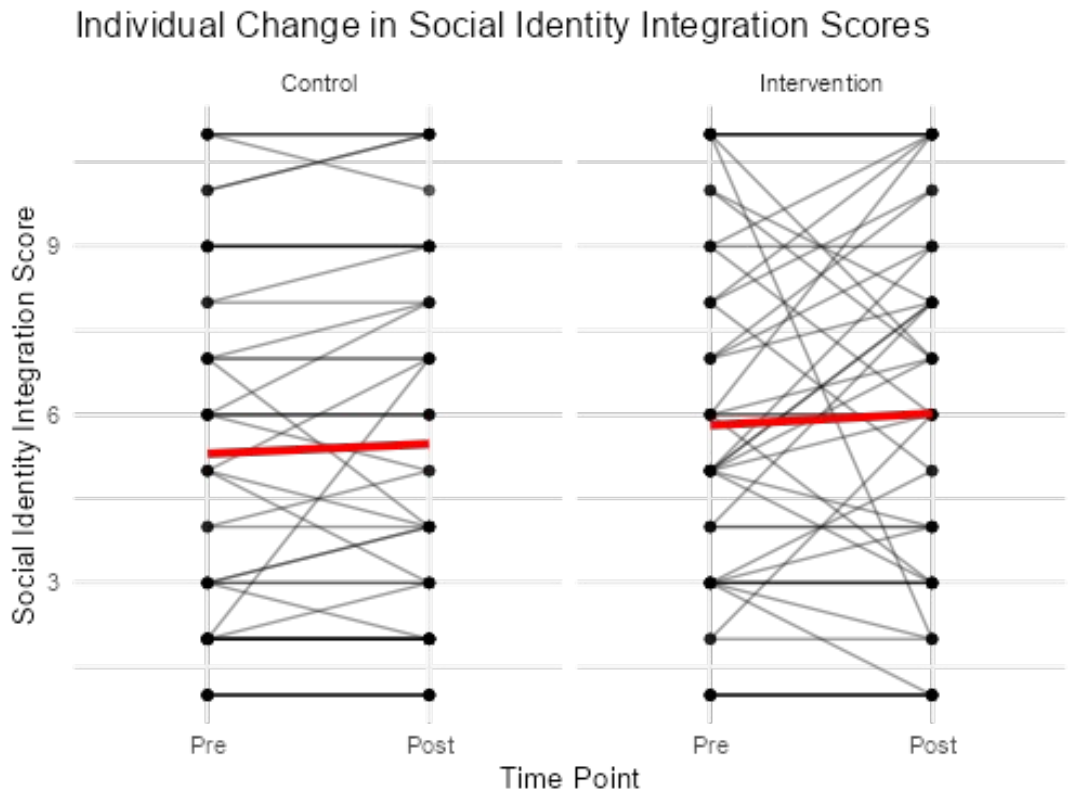


Table 5

Direction of Individual Integration Score Change

Identity Integration pre-post change	Intervention N (%)	Control N (%)
Score decreased	14 (29)	5 (11)
Score stayed the same	19 (39)	29 (63)
Score increased	15 (31)	12 (26)

Baseline Predictors of Increase vs Decrease

To determine if Increasers and Decreasers differed at baseline following the lived-experience video, the two sub-groups were compared on key demographic and clinical variables. The No-Changers were excluded from these specific comparisons. Independent samples t-tests were used for continuous variables. The assumption of homogeneity of variances was violated for both total paranoia scores and HPSVQ scores, as assessed by Levene's test ($p < .05$). Therefore, the results of Welch's t-tests are reported.

There were no significant differences at baseline between Increasers and Decreasers on total paranoia scores, $t(15.7) = 0.304$, $p = .765$, or for HPSVQ scores $t(14.9) = -0.516$, $p = .613$.

For categorical variables, Fisher's Exact Test was used for all comparisons due to small expected cell counts. These analyses revealed no statistically significant differences between the Increaser and Decreaser subgroups based on age group ($p = .869$), ethnicity ($p = .231$), employment status ($p = .814$), level of education ($p = .154$), marital status ($p = .810$), history of psychotic-type disorder ($p = .460$), or prior hospitalisation for mental health ($p = .705$).

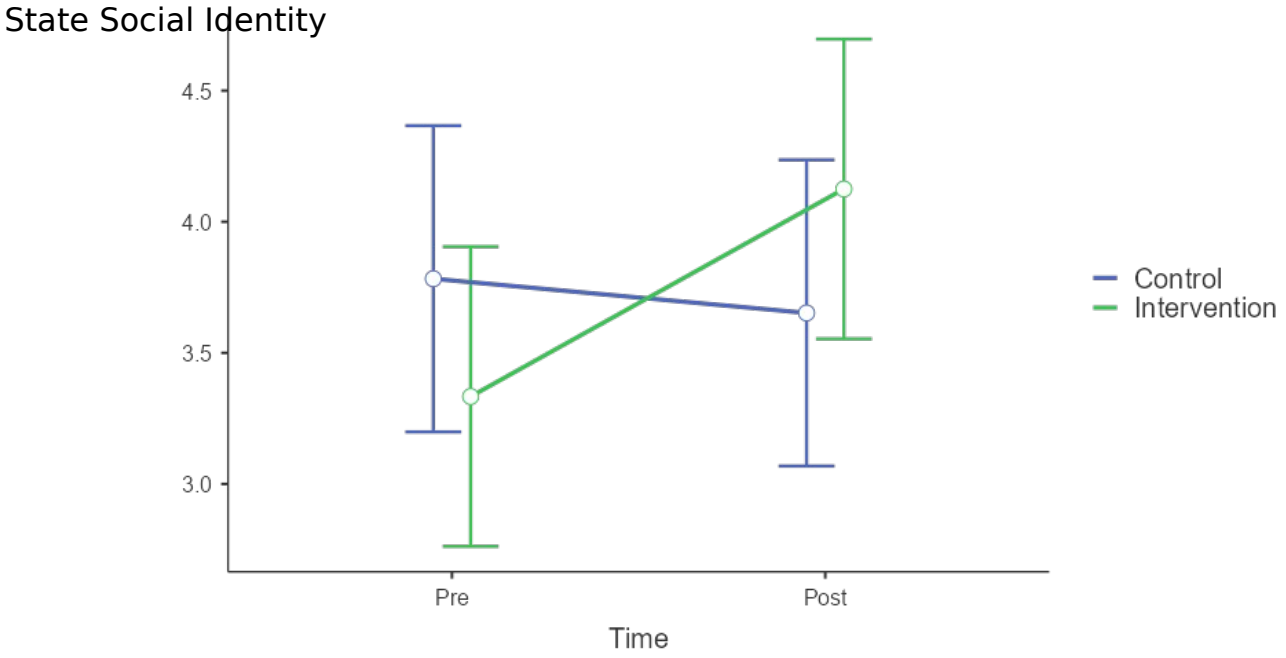
Identity Exploratory Analysis

Exploratory analysis was conducted to examine whether the intervention impacted state voice hearer social identity, measured using identity visual analogue scale. A mixed ANOVA was performed, again with group (intervention/control) as the between-subjects factor and time (pre/post) as a within-subjects factor. Bootstrapping with 10,000 resamples was applied. A significant Group x Time interaction was found $F(1, 92) = 9.32$, $p = 0.003$. The bootstrapped estimate was -0.922 (95% CI [-1.52, -0.338], $p = 0.03$, indicating that change in identification over

time (pre/post) differed significantly between the intervention and control groups, with participants in the intervention group showing a greater increase in identification as voice-hearers than those in the control group. Change over time can be seen in Figure 3.

Figure 3

Social Identity change pre- and post- intervention across groups

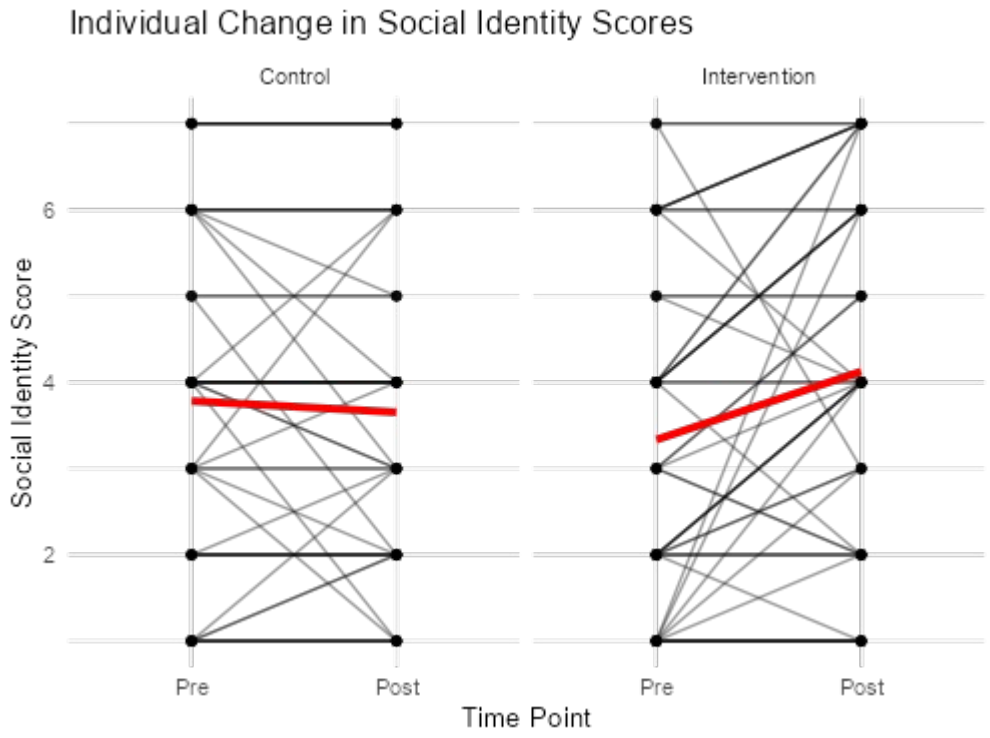


Visual inspection of the spaghetti plot (Figure 4) confirms the overall group-level finding. The mean score (red line) for the intervention group shows a positive trend from pre- to post-intervention, while the mean score for the control group remains almost perfectly flat. A higher percentage of participants in the intervention group experienced an increase in their social identity score (38%) compared to the control group (22%). However, the primary insight from the plot is the considerable heterogeneity of response to the intervention. While the control group was

predominantly stable (67% had no change), the intervention group's response was more varied. It shows that 19% of the intervention group experienced a decrease in their social identity score, higher than that observed in the control group (11%).

Figure 4

Individual Identity Change Scores



Key:

Red line indicates mean

Hypothesis Two

To test the hypothesis that baseline social identity integration predicts change in wellbeing, a multiple linear regression was conducted, with post-video wellbeing as the dependent variable, with baseline wellbeing and baseline integration as predictor variables. Due to violations of the normality of residuals (see Appendix H),

bootstrapped confidence intervals and p-values (10,000 samples) were used for inference.

The overall regression model was statistically significant and accounted for a substantial portion of the variance, adjusted $R^2 = 0.881$, F1, 92 = 344, p<.001.

Within the model, baseline wellbeing was as expected a strong significant predictor of post-video wellbeing (B = 0.966, p<.001). However, baseline integration did not emerge as a significant predictor of post-intervention wellbeing after controlling for baseline scores (B = 0.044, p=.461, 95% CI [-0.077, 0.166]). Therefore, this analysis did not support hypothesis two.

Exploratory Analysis

To explore which baseline characteristics predicted a participant's identity integration score after the video intervention, a standard multiple linear regression was conducted on the intervention group only (N=48). The post-video state identity integration score was the dependent variable. The predictors included the pre-intervention integration score, along with baseline measures of paranoia, voice hearing severity, state identity, and wellbeing.

The statistical assumptions for the regression were met. The test for normality of residuals was non-significant (Shapiro-Wilk p = .118), and a Breusch-Pagan test indicated that the assumption of homogeneity of variance was also met (p = .117). Collinearity statistics were all within acceptable limits (all VIF < 1.7), indicating that the predictors were not overly correlated with one another.

The overall model was statistically significant, $F(6, 87) = 31.5$, $p < .001$, and explained a substantial portion of the variance in post-intervention integration scores (Adjusted $R^2 = .666$).

Examining the individual predictors, the analysis showed that the pre-intervention integration score was the only significant predictor of the post-intervention score ($\beta = 0.826$, $p < .001$). This indicates that as expected, participants who started with a higher level of identity integration also tended to finish with a higher level, regardless of which video they watched. After accounting for this, none of the other baseline variables, such as voice hearing severity ($p = .360$), or paranoia ($p = .277$), were significant predictors of the outcome.

Discussion

This study aimed to examine the impact of watching a video detailing experiences of voice hearing identity integration on participants' own identity integration. Contrary to hypothesis one, the intervention did not significantly affect voice hearer social identity integration, with no significant Group x Time interaction found. This suggests the brief video intervention was not sufficient to change participants' judgement of how integrated they felt their own voice hearer identity was over the short term.

Regarding hypothesis two, the analysis found no evidence to support that baseline voice hearer social identity integration predicted change in wellbeing.

Interpreting the Null Finding for Identity Integration

There are several possible explanations for this null finding regarding identity integration. First, identity integration is a relatively stable construct, and one that is developed through time and often through interaction (Amiot et al., 2007). Hogg et al.

(2023) found that the perception of empathy towards voice hearers in those who do not themselves hear voices was important for identity integration, therefore it is possible that ‘in-group’ stories are not sufficient to promote state integration change. A one-size-fits-all video of voice hearers talking about their experience may also not be specific or intensive enough to make state changes on integration. During piloting, experts by experience emphasised the importance of not sugarcoating stories, and so while stories were overall positive, it is possible that if someone is not in a social context where social identity integration can happen, then the challenges may be focused upon by the viewer. This fits with the Cognitive-Developmental Model of Social Identity Integration that highlights ‘feelings of threat’ as inhibitors of integration (Amiot et al., 2007). These findings suggest that while brief narrative interventions may influence how individuals identify with a group, promoting integration of that identity may require more sustained or interactive approaches. Future research could explore repeated exposure with peer-led content or alternative interventions that might more effectively foster integration.

Interpreting the Exploratory Finding for Voice Hearer Identity

Exploratory findings indicated that although state integration was not altered by the lived-experience video, state identity was. Identity integration is largely socially constructed and shaped over time (Amiot et al., 2007). In contrast, individual identity, while still influenced by social factors, is more personal and therefore potentially more responsive to the video. This suggests that brief lived-experience videos may be more effective at enhancing sense of identification for voice hearers than at fostering a deeper integration of that identity into one’s self-concept.

Individual Differences and Heterogeneity of Response

Descriptive statistics showed heterogeneous integration responses to the lived-experience video, with many increasing but also many decreasing. Exploratory analysis looking at the ‘increaser’ and ‘decreaser’ subgroups within those who received the lived-experience videos showed no significant differences between baseline variables.

The sample were close to the mid-point for their identity and identity integration scores pre-intervention. The findings should be considered in the context of this, and it is possible that a sample with much lower or higher levels pre-video would have different outcomes. The wellbeing scores were lower than those found in other studies of people with schizophrenia, which may have impacted participants’ responses to the videos. The paranoia scores found within the sample were similar to scores of high but non-clinical paranoia in other studies (Sood et al., 2021). This paranoia may have increased scepticism or mistrust about the video, particularly given that experiences of restrictive and risk-averse mental health practices can lead to understandable mistrust of such interventions, which may have impacted individual’s responses to the video. Though this was not a clinical sample, the moderate levels of paranoia and voice hearing severity may mean that the findings have some generalisability to clinical populations, though it would be important to complete further research to explore the use of such videos in a clinical context.

Relationship between Identity Integration and Wellbeing

The findings suggest that within this sample, the degree of social identity integration may not have a direct impact on wellbeing outcomes. This contrasts with Hogg et al. (2023) who found that integration of a voice hearer social identity was strongly predictive of better psychological wellbeing 6 months later. It is possible that the

relationship between voice hearer social identity integration and wellbeing is more complex. Wellbeing, while having a stable component, also has state fluctuations (e.g. mood); a cross-sectional measure of wellbeing might be more influenced by these temporary states, compared with Hogg et al.'s (2023) longitudinal findings. Future research including qualitative or ecological momentary analysis approaches may offer richer insights into the relationship between integration and wellbeing.

Video Delivery Considerations

The mode of video delivery should be considered. In our randomised study, participants viewed the video after providing informed consent, but without having actively sought out this content. Information on the video beforehand were intentionally minimal to avoid priming participants. This delivery contrasts with the user-driven engagement seen in other contexts. For instance, Naslund et al. (2014) found that individuals with severe mental illness gain benefits such as hope, reduced isolation, and peer support through their own volition in accessing lived-experience YouTube videos. Differences in motivation and active seeking behaviours may limit the videos impact when delivered within a controlled research setting compared with self-initiated viewing.

Methodological Considerations

The non-normality of the data may mean some assumptions of analyses were violated. This was addressed through bootstrapping for robust estimates. This sample heterogeneity might reflect important real-world patterns, suggesting that while some participants strongly integrate their voice hearer social identity into their wider sense of self, others may have limited integration. Distinct subgroups or profiles may exist among voice hearers, with potentially different responses to

interventions. As the individual scores showed, there were fewer scores that stayed the same in the intervention group, possibly suggesting that while the video made some scores go up, it in fact caused some to go down. Future development of videos would need to consider this.

Limitations

The current study had several limitations. First, social identity integration and wellbeing are complex, multifaceted constructs, that may not have been fully captured by state measures. Potential moderating or mediating variables such as stigma and social support were not examined.

The requirement for computer/smartphone access for participation limits generalisability to populations who lack financial means or digital literacy. Furthermore, the study required some degree of identification as a voice hearer, meaning findings cannot be extrapolated to those with limited or fluctuating insight into their experiences.

The current study used a video compiled of several lived-experience stories and while a range of demographics and experiences were sought, it was not possible to ensure vignettes resonated with everyone. While ratings were collected for how engaging and relevant the videos were, the absence of qualitative data due to anonymity and risk constraints, limited deeper understanding of the observed impacts.

Conclusion

In this study it was found that a lived-experience video about social identity integration did not significantly alter state measure of identity integration score compared with a control group. Baseline identity integration scores did not

significantly predict wellbeing scores. Exploratory analyses indicated that the lived-experience video did significantly increase voice hearer identity scores, compared with the control group Future research should aim to explore what works, and for whom, in promoting voice hearer identity integration, as well as further investigating the relationship between integration and wellbeing.

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Executive Summary

Social Identity, Identity Integration, and Wellbeing in Voice Hearers: An Experimental Investigation

Research has shown that for people who hear voices, having a voice hearer identity that it well-integrated within a wider sense of self predicts improved wellbeing. Identity integration is the final step of a four-step process of incorporating a new aspect of one's identity into an overarching self-concept. Lived-experience videos, in which someone describes their personal experience of mental health, have been found to be beneficial in reducing the stigma associated with this. Such videos are prolific on social media. There is currently no research exploring the impact of a voice hearer lived-experience video on voice hearer social identity integration, as well as investigating the impact of integration on wellbeing.

An experimental study was conducted, where 94 participants who identified as hearing voices were presented with one of two videos: a lived-experience video about the process of voice hearer identity integration, or a control video about the weather. Before and after watching the video, participants were asked to complete a range of outcome measures, including measures of identity, identity integration and wellbeing. Participants also rated how engaging and relevant they found the video.

Statistical analysis demonstrated that the lived-experience video did not significantly change state measures of identity integration for voice hearers, compared with the control group. Further, integration did not predict post-video wellbeing. Exploratory analysis found that for those who watched the lived-experience video, their state score of identity did significantly increase compared with the control group. There

was great variability in changes of scores, indicating that the video impacted people differently. Overall, findings suggest that this video intervention was not able to increase state integration but could increase identity, though these findings are exploratory and so should be taken cautiously. This may suggest that identity integration is a stable and slow-to-change construct, which may require more active interventions. Future research should aim to assess other factors that increase voice hearer identity and explore what works and for who.

Connecting Narrative

An unexpected thread that was woven through each of my projects was the complex nature of disclosure. While I didn't set out with this theme in mind, my research has led me to a profound appreciation of the messiness of sharing one's struggles, the critical (and at times long-lasting) impact of those who listen, and the responsibility we hold when entrusted with someone's story.

I originally considered a theory-driven research project on suicide but felt ethically this might be too challenging. This led me to consider a literature review on suicide and self-harm, and as I previously completed an undergraduate research project on health and social media, I was drawn to explore this. The review highlighted the dual nature of these platforms for offering connection while also exposing individuals to risk. Understanding the literature became relevant during my placement in a brief intervention service for self-harm and was likely shaped by conversations around triggering content.

My interest in digital media and lived experience drew me to choosing my theory-driven research project topic. Initially, I hoped to feature real people telling their stories, but the ethical complexities of sharing identifiable content that could be accessed by people they knew made this unfeasible. This exposed my own biases: my belief that these experiences should not be a source of stigma or shame was put into perspective by the experts by experience that I spoke to who confirmed how carefully they must consider what they disclose and to whom, for their safety. This was a reminder of the gap between a clinician's perspective and the societal reality for many. Through problem-solving with my supervisors and experts by experience,

we decided to develop scripts that actors would read out. This process was daunting; I felt a heavy responsibility to honour the experts by experiences' truths, while moulding stories into the theoretical concept of 'identity integration'.

My research also brought practical challenges. Having previously recruited through NHS pathways, the non-NHS recruitment for this study was a steep learning curve in outreach and trust-building. Recruitment was also a significant hurdle in my SIP. My initial idea for a staff focus group proved impossible due to the logistics of gathering busy clinicians. Service users were also challenging to recruit, and in grappling with this in supervision we decided to supplement our findings with quantitative data. We were, however, constrained by what had been routinely collected, which limited my focus to group data and revealed lots of missing data, teaching me the importance of high-quality routine outcome measures in clinical work.

Despite these challenges, the SIP was incredibly rewarding. It was a pleasure to have an assistant psychologist support the project, and having her perspective as someone connected to the service was invaluable for reflecting on client interviews. I was conscious of how our shared lens might bias my interpretation, using a reflexive journal to navigate this. The project culminated in presenting at a neurodivergence conference, which was a fantastic opportunity to see how other teams are upskilling and to share our service's learning.

The thread of disclosure has not just run through my research; it has directly informed my clinical work. Learning about creating safe spaces for sharing shaped my stance, the content, and the conversations within the Unusual Experiences and Psychosis group I established on my inpatient placement. My entire research journey has reinforced that whether it's in an online forum, a co-produced video, or a therapy

room, disclosure is a delicate process requiring safety, respect, and a willingness to adapt. Looking ahead, I am keen to carry this forward, and while I recognise the challenge of balancing research with clinical demands, I envision continuing to contribute to the evidence base, ensuring that the voices of those with lived experience continue to refine the support offered.

Acknowledgements

First, I would like to thank the experts by experience who shaped my projects, with special mention for those who shared their story. Your expertise was fundamental and invaluable. I am also incredibly grateful to all the participants who generously gave their time and shared their experiences. It is moving to see people use their experiences for the betterment of others through research. Thank you also to anyone who shared my research advert, and especially to the various Hearing Voices groups, both for the incredible work you do, and for your commitment to research engagement.

I am very grateful to my supervisors. Ceara, for being my course tutor, and for calm reassurance and practical support no matter how stressful things were. Louise and Lorna, thank you for your theoretical and research expertise, helping me to cut through complex problems with clarity, and to keep going when things felt difficult. Matthew, thank you for your generosity of compassion and time, and for shaping me to be a better researcher.

My journey through this doctorate has been shaped by exceptional clinical supervisors, each bringing something different to my understanding of how to be a clinical psychologist. My sincerest thanks to Steph, who was the best first placement supervisor I could've asked for and whose support has continued long since. I am also thankful to the entire Bucks Psychological Therapies team, with a special mention for (trainee-to-be) Irene. Her passion for understanding clients' experiences is truly inspiring, and I am grateful for the times she went above and beyond.

This thesis would not have been possible without the creative contributions of others. I am particularly grateful to the actors, Jackie, Nike, and Paul, who selflessly gave their time and endured what felt like a million retakes to make the retelling of the experts by experiences' stories the best they could be. Thank you for your time and your respect.

I could not have completed this journey without my support system. To my brother and my sister-in-law, thank you for everything: the practical, the emotional, and the spreadsheet support. Your selflessness, especially while navigating your own significant life events, has been a humbling and constant source of strength. Eithne, thank you for your generous wisdom. To my friends, thank you all for keeping me going and for your unwavering understanding through it all.

Although no longer with us, I want to thank my dad, for being a constant source of inspiration (though 'If Quinn is wrong, she is wrong' plays in my head when I think about him reading this thesis…). To mum, there simply aren't the words to express my gratitude, but you are my foundation, and you deserve at least half of this doctorate for your never-ending emotional support and excellent ~~nitpicking~~ proofreading skills. I would also like to thank Maureen, the kindest person I know, for the cups of tea, the laughs, and for instilling in me a desire to make a difference.

It truly takes a village to get a trainee through the DClinPsy, and what a village I've had. Thank you all.

Appendices

SRL Appendix A: Full database search terms and number of results

PsycINFO

Date of Search: 01/04/2025

Number of results: 1,696

#	Search string	# of results
1	("Social media" or "social network*" or facebook or instagram or snapchat or reddit or tiktok or twitter or WhatsApp or Online or Internet or Website* or "Digital Media" or "Computer Mediated Communication" or "Electronic Communication" or "Web site*" or Blog* or "Instant Messag*" or "You Tube" or Tumblr or WeChat or Weibo or "YouTube").ab,id,ti.	249,456
2	social media/ or computer mediated communication/ or digital media/ or online social networks/ or blog/ or internet/ or online community/ or social network analysis/ or virtual group dynamics/ or websites/	72,071
3	1 or 2	256,962
4	(Suicid* or "harm to self" or "self-harm*" or "self harm*" or "self injur*" or "Self-Injur*" or "Self Destructive Behavio*" or "Self-Destructive Behaviou*" or "Self Poison*" or "Self-Poison*" or Overdose or "Self-Inflicted Wound*" or "Self Inflicted Wound*" or "Self-Mutilat*" or "Self Mutilat*" or Parasuicid* or "Ending Own Life").ab,id,ti.	100,531
5	self-destructive behavior/ or nonsuicidal self-injury/ or suicidal behavior/ or self-poisoning/ or suicidal ideation/ or suicidality/ or suicide/ or youth suicide/ or suicide prevention/ or suicidology/ or self-inflicted wounds/	57,498
6	4 or 5	101,650
7	(Teen* or Adolescen* or "Young Person" or "Young People" or Youth* or Minor* or "Young Adult*").ab,id,mh,sh,ti	818,283
8	3 and 6 and 7	2,093
9	limit 8 to yr="2009 -Current"	1,965
12	limit 9 to peer reviewed journal	1,696

PubMed

Date of Search: 01/04/2025

Number of results: 1,867

#	Search string	# of results
1	“Social media"[tiab] OR "social network*"[tiab] OR facebook[tiab] OR	

	instagram[tiab] OR snapchat[tiab] OR reddit[tiab] OR tiktok[tiab] OR twitter[tiab] OR WhatsApp[tiab] OR Online[tiab] OR Internet[tiab] OR Website*[tiab] OR "Digital Media"[tiab] OR "Computer Mediated Communication"[tiab] OR "Electronic Communication"[tiab] OR "Web site*"[tiab] OR Blog*[tiab] OR "Instant Messag*"[tiab] OR "You Tube"[tiab] OR Tumblr[tiab] OR WeChat[tiab] OR Weibo[tiab] OR "YouTube"[tiab]	455,917
2	"social media"[MeSH Terms] OR "online social networking"[MeSH Terms] OR "blogging"[MeSH Terms] OR "internet"[MeSH Terms] OR "internet use"[MeSH Terms] OR "social media"[MeSH Terms] OR "online social networking"[MeSH Terms] OR "blogging"[MeSH Terms] OR "internet"[MeSH Terms] OR "internet use"[MeSH Terms]	106,407
3	#1 OR #2	495,569
4	Suicid*[tiab] or "harm to self"[tiab] or "self-harm*"[tiab] or "self injur*"[tiab] or "Self Destructive Behavio*"[tiab] or "Self Poison*"[tiab] or Overdos*[tiab] or "Self-Inflicted Wound*"[tiab] or "Self-Mutilat*"[tiab] or Parasuicid*[tiab] or "Ending Own Life"[tiab]	149,817
5	“self-injurious behavior”[MeSH Terms] OR “suicidal ideation”[MeSH Terms] OR “suicide”[MeSH Terms] OR “suicide prevention”[MeSH Terms] OR “self-mutilation”[MeSH Terms] OR “suicide, completed”[MeSH Terms] OR “suicide, attempted”[MeSH Terms]	89,621
6	#4 OR #5	168,964
7	Teen*[tiab] or Adolescen*[tiab] or "Young Person"[tiab] or "Young People"[tiab] or Youth*[tiab] or Minor*[tiab] or "Young Adult*"[tiab]	992,954
8	#3 AND #6 AND #7	1,944
9	("2009/01/01"[Date - Publication] : "3000"[Date - Publication])	19,383,754
10	#8 AND #9	1,867

Scopus

Date of Search: 01/04/2025

Number of results: 4,439

#	**Search string**	**# of results**
1	TITLE-ABS-KEY (“Social media” or “social network*” or facebook or arasuici or snapchat or reddit or tiktok or twitter or WhatsApp or Online or Internet or Website* or “Digital Media” or “Computer Mediated Communication” or “Electronic Communication” or “Web site*” or Blog* or “Instant Messag*” or “You Tube” or Tumblr or WeChat or Weibo or YouTube)	2,281,009
2	AND TITLE-ABS-KEY (parasui* OR “harm to self” OR “self-harm*” OR “self harm*” OR “self injur*” OR “Self-Injur*” OR “Self Destructive Behavio*” OR “Self-Destructive Behaviou*” OR “Self Poison*” OR “Self-Poison*” OR overdose OR “Self-Inflicted Wound*” OR “Self Inflicted Wound*” OR “Self-Mutilat*” OR “Self	11,969

	Mutilat*” OR parasuicide* OR “Ending Own Life”)	
3	AND TITLE-ABS-KEY (Teen* or Adolescen* or “Young Person” or “Young People” or Youth* or Minor* or “Young Adult*”)	4,621
4	#1 AND #2 AND #3	4482
5	2009-2025	4,439

Web of Science

Date of Search: 01/04/25

Number of results: 5,587

#	**Search string**	**# of results**
1	"Social media" OR "social network*" OR facebook OR instagram OR snapchat OR reddit OR tiktok OR twitter OR WhatsApp OR online OR internet OR website* OR "digital media" OR "computer mediated communication" OR "electronic communication" OR "web site*" OR blog* OR "instant messag*" OR "You Tube" OR tumblr OR wechat OR weibo OR "YouTube"	3,283,379
2	Suicid* OR "harm to self" OR "self-harm*" OR "self harm*" OR "self injur*" OR "Self-Injur*" OR "Self Destructive Behavio*" OR "Self-Destructive Behaviou*" OR "Self Poison*" OR "Self-Poison*" OR overdose OR "Self-Inflicted Wound*" OR "Self Inflicted Wound*" OR "Self-Mutilat*" OR "Self Mutilat*" OR parasuicid* OR "Ending Own Life"	287,665
3	Teen* OR Adolescen* OR "Young Person" OR "Young People" OR Youth* OR Minor* OR "Young Adult*"	4,858,878
4	#1 AND #2 AND #3	6,214
5	PY=(2009-3000)	5,862
6	NOT: Document Types: Review Article	5,587

SRL Appendix B: Archives of Suicide Research Journal Submission Guidelines

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Contents

- About the Journal
- Open Access
- Peer Review and Ethics
- Preparing Your Paper
    - Structure
    - Word Limits
    - Format-free Submission
    - Taylor & Francis Editing Services
    - Checklist: What to Include
- Using Third-Party Material
- Submitting Your Paper
- Data Sharing Policy
- Publication Charges
- Copyright Options
- Complying with Funding Agencies
- Accepted Manuscripts Online (AMO)
- My Authored Works

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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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On publication, you will be able to view, download and check your article's metrics (downloads, citations and Altmetric data) via My Authored Works on Taylor & Francis Online. This is where you can access every article you have published with us, as well as your free eprints link, so you can quickly and easily share your work with friends and colleagues.

We are committed to promoting and increasing the visibility of your article. Here are some tips and ideas on how you can work with us to promote your research.

SIP Appendix A: Practitioner Points

Practitioner Points

- Neurodivergent individuals in DBT often struggle to notice and articulate their needs; therefore clinicians should proactively and flexibly explore and offer individualised adaptations, rather than relying on a uniform approach.
- Adapted DBT groups can significantly enhance neurodivergent clients' sense of acceptance and relatability with mental health services, even if dropout and attendance rates remain similar to non-adapted groups.
- Lower attendance should be considered but can also reflect challenges with neuronormative expectations: focus should be on genuine client engagement.
- Clinicians should recognise that negative past experiences with mental health services and a lack of external support (family/other services) can hinder neurodivergent clients' engagement; consider additional scaffolding for those without such support.

SIP Appendix B: Adapted versus non-adapted group differences

Non-adapted Group	Adapted Group
14-17 sessions of 2 hours	33 sessions of 1 hour 15 minutes
One session weekly	Two sessions weekly, one at start of week for teaching new content, one at end of week for reviewing homework and for group practice
Session plan: **10 minutes of mindfulness, 40 minutes homework review, 10-minute break, 60 minutes teaching content**	Session Plan: Session 1: 5 minutes of mindfulness, teaching content, 10-minute break, finish teaching content Session 2: 5 minutes of mindfulness, home practice review, 10-minute break, finish home practice review
Lots of acronyms to make concepts easier to remember (e.g. DEARMAN)	Limited acronyms; heavier focus on content; reduced content
If participants were late, they had to wait until 10-minute mindfulness is over to avoid disruption to wider group	Participants allowed through lobby during mindfulness so they can join part way through, to minimise amount of mindfulness missed
Teaching based on Linehan's DBT manual, covering mindfulness, then emotional regulation, distress tolerance, and interpersonal effectiveness skills, as per group in Neacsiu et al. (2014)	Teaching based on Wise's Neurodivergent Friendly Workbook of DBT Skills and Linehan's DBT manual (Wise, 2022). Each participant was sent a physical copy of the former book to keep and work through
Psychoeducation on emotional dysregulation, with additional discussion of issues specific to the individuals (including neurodivergence where relevant)	Psychoeducation on emotional dysregulation, autism, and the interplay of these. This includes teaching on masking, autistic pride, meltdown mapping, and sensory needs
Session plans and homework sheets all sent at the start of the course, with weekly labels	Weekly emails sent with slides, materials (homework sheets and information sheets) and summary of session. Link to join

	meeting resent every week
Group members called or emailed later in the day if they did not show up	Group members called by Assistant Psychologist during the first 10 minutes of the group (during mindfulness) to encourage them to attend
Did Not Attend (DNA) policy of 3 missed sessions adhered to unless specific extenuating circumstances	Flexible DNA policy to allow people to continue attending no matter how many missed sessions
Group members encouraged to talk using microphone. Members picked by facilitators throughout mindfulness and homework review to feedback	Group members encouraged to speak or use MS Teams chat function depending on preference
Use of sensory items allowed	Use of sensory items encouraged at start of group

SIP Appendix C: Standards for Reporting Qualitative Research guidelines

Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement
Purpose or research question - Purpose of the study and specific objectives or questions

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field
Limitations - Trustworthiness and limitations of findings

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting

***The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.*

The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

SIP Appendix D: Service User Semi-Structured Interview Schedule

Questions for Service Users

I am going to ask you some questions about your assessment [and therapy] with the psychological therapies team. It would be very helpful to hear about how you found this. You can tell me how this was honestly, whether that was good, bad, or anything else. If there's anything I say or ask that isn't clear please tell me and we can discuss it, you could say 'I don't understand'. If you don't want to answer any question you don't have to, you can say 'can we skip this'.

Do you have any questions before we begin?

Those who have completed assessment:

How did you experience the assessment process as a neurodivergent person?

Follow up: What did you like about the process? What did you dislike? Could you tell me about the set up (physical environment, timing etc) of the meeting and did you have any physical or emotional feelings when this happened? Could you tell me about the actual assessment meeting itself and if you had any physical or emotional feelings during this? How did you feel after the meeting?

How did you find the process of opting in for an assessment? What was the impact of that on how you were able to engage with the therapy?

How did you find the process of booking the assessment? What was the impact of that on how you were able to engage with the therapy?

Did the clinician doing the assessment ask about any adaptations that you might need? What was the impact of that on how you were able to engage with the therapy? *Follow up if needed: For instance did they check if you might need a break/if you needed questions repeating or rewording?*

Is there anything you would have liked before coming to an assessment with Psychological Therapies? *Follow up if needed: for instance, some people prefer to have a picture of the assessing clinician, or an email reminder.*

Would you want anything to be different during the assessment, to better suit your needs?

Would you want anything to be different after the assessment, to better suit your needs?

If you've accessed other services or therapies, did you feel they catered for your neurodivergence? If so/not, why?

Those who have experienced therapy/group therapy

What was your experience like of [DBT/Skills group/Emotion Coping Skills group]? *Follow up if needed: what was the impact of that on how you were able to engage with the therapy?*

What was it like to be in the group/therapy as a neurodivergent person? *Follow up if needed: Did you have any physical or emotional feelings as a result of being a neurodivergent person in the group/therapy?*

Did you feel the content of your group/therapy sessions was given in a way that took account of any specific needs you feel you have resulting from your neurodivergence? What was helpful/not helpful? Would you make any changes?

Did you feel the service was aware of any specific needs you have resulting from your neurodivergence when it came to the therapy provided? Do you feel that these needs were met?

Were there any barriers or obstacles in accessing the group/therapy resulting from your neurodivergence? If so, what were the barriers? Follow up if needed: Was there anything that got in your way of accessing the group/therapy?

What do you think could be done to improve access for people with neurodivergence in this service?

If you've accessed other services or therapies, how did your experience of this compare with previous services?

Those that dropped out:

What led to your decision to leave the therapy/group? What was the impact on you following leaving the group/therapy?

SIP Appendix E: Service User Pre-Interview Information

E1. Information sheet – easy read:

Understanding neurodivergent clients experience of assessment and therapy within the Buckinghamshire Psychological Therapies Team

Information Sheet – Easy read

- We would like to speak to you about your experience of the Psychological Therapies service.
- Before you decide about taking part, it is important for you to understand why the project is happening and what it will involve.
- Please read the below information. If you have any questions or wish to talk about the project before deciding the take part, please contact the principal researcher, Roisin Quinn (Trainee Clinical Psychologist).
- This project is being undertaken under the supervision of Dr Stephanie Capon and Dr Ceara Moore.

What will happen?

- We will ask you to take part in an interview either via Microsoft Teams (MS Teams) or in person at Saffron House, High Wycombe (https://www.accessable.co.uk/oxford-health-nhs-foundation-trust/access-guides/saffron-house) depending on what you would prefer.
- This interview may last up to 1 hour.
- You will be given numerous date and time slots to choose from.
- You will be asked some questions about yourself (age range, gender, ethnicity).
- In the interview, you will be asked about your experience and opinion of having an assessment and/or therapy with the team. This may include your personal views of your DBT individual or skills group session, or the Emotional Coping Skills group.

Why is the project happening?

- This project aims understand the experience of neurodivergent people, to know what's working well and suggest improvements.

Do I have to take part?

- You do not have to take part in this project.
- If you decide to take part but later change your mind, you can withdraw at any stage, including stopping the interview or getting rid of your data after the interview.
- You don't have to answer all of the questions if you don't want to.

How will my data be used?

- The interview will be audio recorded using Microsoft Teams.
- Your data (what you say) will be stored securely.
- Data will be processed in accordance with the legal requirements to keep it safe.
- The data you provide will be anonymised and may be published but no identifiable data will be used.
- Project data will be stored as detailed for five years after publication of the project.

Who will have access to my data?

- Roisin Quinn will have access to all data, the project supervisors will have access to anonymised transcripts (write-up of what you say).
- The project will be written up and published in a scientific journal and a copy will be stored in Oxford University archives.

Who has approved the study?

- This project was approved by the programme panel and has ethical approval from the Trust audit tracking team.

Please contact Roisin Quinn (roisin.quinn@hmc.ox.ac.uk) or the project supervisors Ceara Moore (ceara.moore@hmc.ox.ac.uk) or Dr Stephanie Capon (PsychologicalServices.SouthBucks@oxfordhealth.nhs.uk) if you have questions or concerns.

Thank you for reading.

E2. Communication Preferences (also sent as Microsoft Forms link if preferred):

Communication preferences

We know that everyone is different but want to ensure that any preferences are respected - please fill it in and let us know if you have any additional ideas. You do not have to fill in every box.

I would prefer to meet:

☐ Face to face ☐ Online (Microsoft Teams)

Would you like someone to come with you into the meeting?

☐ Yes ☐ No

Would you prefer to have any of the following:

☐ Be sent the questions in advance

☐ Have the questions typed into the chat box/on paper

☐ Pen and paper to make notes

☐ A break scheduled into the meeting

☐ A phone call or text beforehand

☐ Other:

Do you have any sensory needs you would like us to be aware of?

Examples: I prefer bright lights off. I prefer certain times of day. I would like to wait outside before the meeting.

Are there other communication preferences you would like us to know?

Examples: I find long sentences difficult to follow. I find it hard to tell people when I don't understand. I prefer people to not make jokes. I find it hard to talk when I first meet someone. I prefer emails to phone calls. I like to have questions written and visible (e.g. printed or shared on screen). I would prefer for chairs to not be directly facing each other so we don't have to make direct eye contact.

Is there anything else that you would like to say?

E3. Full Information Sheet:

Understanding neurodivergent clients experience of assessment and therapy within the Buckinghamshire Psychological Therapies Team

General Information
We are inviting individuals who have attended assessment and/or therapy (group or individual) to take part in a 1-1 interview about their experience.

Before you make a decision about participation, it is important for you to understand why the project is being done and what it will involve. If after reading the below information, you have any questions or wish to talk about the project before deciding the take part, please contact Roisin Quinn who is leading on this project (contact details can be found at the bottom of the page).

What is involved?
We will ask you to take part in an interview either via Microsoft Teams (MS Teams) or in person at Saffron House, High Wycombe (https://www.accessable.co.uk/oxford-health-nhs-foundation-trust/access-guides/saffron-house) depending on how you feel most comfortable. This interview may last up to 1 hour. You will be provided with numerous date and time slots to choose from. There will also be opportunities to take a break.

You will be asked to answer some demographic questions (age range, gender, ethnicity) which may serve to contextualise the information you choose to provide at interview. In the interview, you will be asked about your experience and opinion of your experience of assessment and therapy within the Buckinghamshire Psychological Therapies Team.

This may include your personal views of your DBT individual or skills group session, or the Emotional Coping Skills group.

Why is this project being conducted?
The South Buckinghamshire Psychological Therapies team recognises the importance of acknowledging that neurodiverse people may have different needs, and the team are committed to catering to these people. This project aims to gather neurodivergent service users experiences of assessment and therapy process and provide recommendations for improvement.

Do I have to take part?
You do not have to take part in this project, participation is voluntary. Should you decide to take part but later change your mind, you may withdraw at any stage. This includes terminating the interview or withdrawing your data after data collection. If you do decide to take part but do not wish to answer all of the questions, you may decide to decline any or all of the questions.

How will my data be used?
Interviews will be recorded using MS Teams platform and stored as an electronic file on the principal researchers' password-protected University of Oxford Microsoft OneDrive. The

videos will be transcribed by the principal researcher and stored in the same manner. Data will be processed in accordance with the General Data Protection Regulation 2018 (GDRP). The data you provide will be anonymised and may be disseminated in various ways such as use in academic publications, conference presentations and/or reports. Although direct quotes may be used, no identifiable data will be associated.

Project data will be stored as detailed for five years after publication of the project.

Who will have access to my data?
The principal researcher will have access to all data. The project supervisor will have access to the anonymised transcripts. Please note, this project is being completed by the principal researcher as partial fulfilment of the Doctorate in Clinical Psychology at the University of Oxford. As such, it will be written up and submitted for publication to a scientific peer reviewed journal and a copy will be stored in Oxford University archives.

Who has reviewed this project?
This project was proposed to the OxICPT-R Project Approval Session (PAS) panel and considered appropriate to investigate. Subsequently, the project has received ethical approval from the Oxford Health NHS Foundation Trust Audit Management and Tracking (AMaT) team.

Who is involved with the project?
The principal researcher on the project is Roisin Quinn, Trainee Clinical Psychologist at the University of Oxford. This project is being undertaken under the supervision of Dr Stephanie Capon and Dr Ceara Moore.

Who do I contact if I have a concern about the project or I wish to complain?
Please contact Roisin Quinn (roisin.quinn@hmc.ox.ac.uk), the project supervisor Dr Ceara Moore (ceara.moore@hmc.ox.ac.uk), or Dr Stephanie Capon (PsychologicalServices.SouthBucks@oxfordhealth.nhs.uk) should you have any questions or concerns about the project. We will aim to acknowledge your concern within 10 working days.

Thank you for reading this information sheet and for considering taking part in this project.

E4. Consent Form:

Oxford Institute of Clinical Psychology Training & Research
Oxford Doctoral Programme in Clinical Psychology
Service Improvement Project

RECORD OF CONSENT FOR PARTICIPATION

Trainee Name:	Roisin Quinn
Supervisor Name:	Dr Stephanie Capon, Dr Ceara Moore
Date of Recording:	

I have had explained to me the purpose of the project and have had opportunity to have my questions answered.

I agree to a recording being made and for it to be transcribed, with an anonymised transcript being used to inform the service improvement project. Direct quotes may be included in the write up, with identifiable information removed.

I understand that the recording will be kept in a secure place and encrypted format and deleted as soon as it has been used for the purpose it is being made.

I agree to the project being written up and published. No identifiable information will be included in this.

I understand that I can withdraw my consent to the above at any time and that this will not affect the service I receive.

Signed:	
Print name:	
Date:	

SIP Appendix F: Staff Survey Questions

For the purposes of this study, 'neurodivergent clients' is focusing on clients with ADHD, and/or autistic clients.

1. What is your experience of **assessing** neurodivergent clients?

Additional questions: How do you adapt your practice when assessing a neurodivergent client for therapy (as part of a BPT suitability assessment)?

Feel free to give specific (anonymous) examples.

2. What **barriers/difficulties** do you come across in your **assessments** with neurodivergent individuals? (e.g. service, personal, related to a clients presentation)

How have you overcome these?

Have you experienced any barriers in your attempts to adapt?

3. What is your perception of what neurodivergent clients may need in **individual or group therapy**?

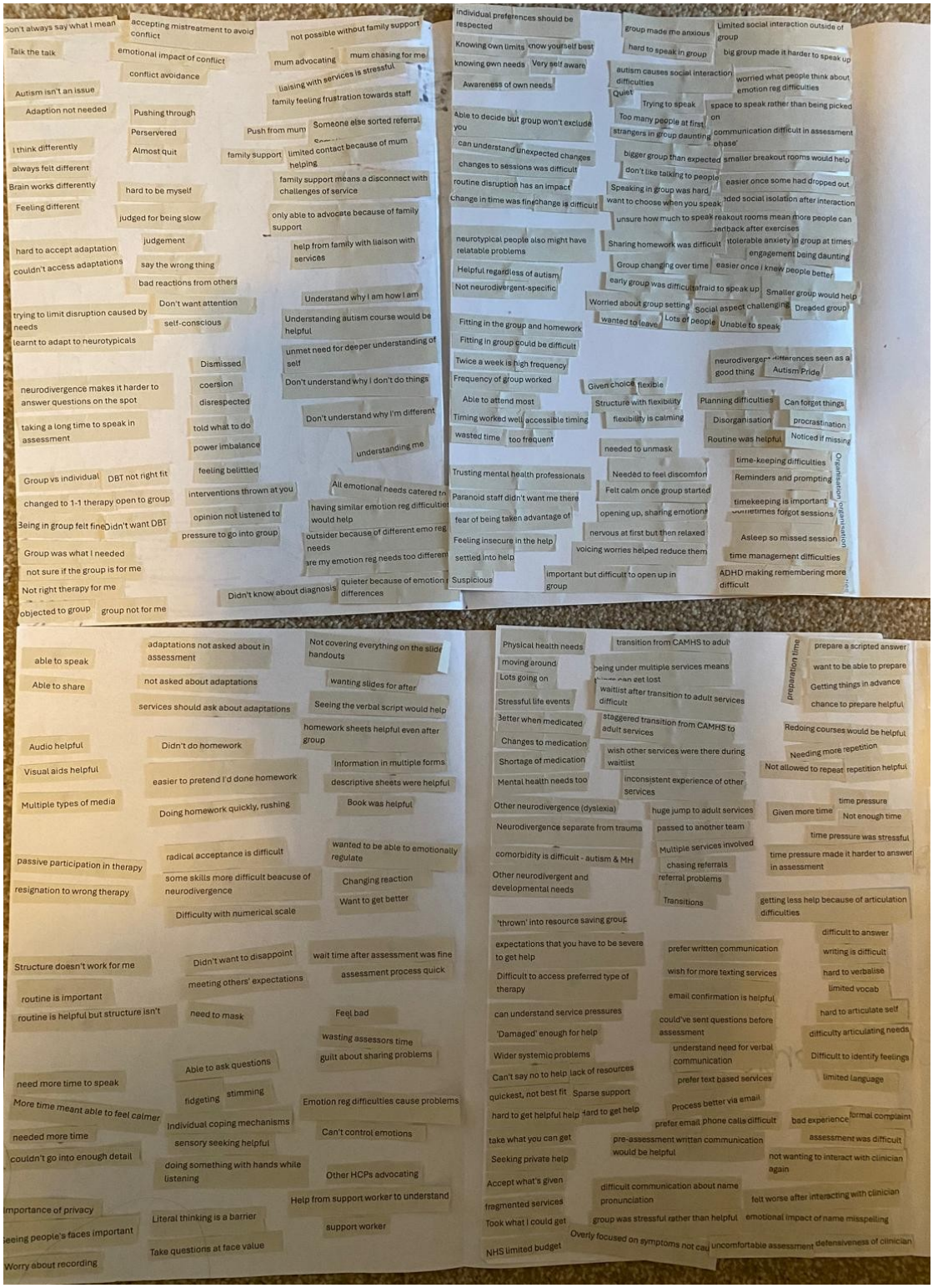
Additional questions: How do you adapt your practice when conducting therapy with neurodivergent clients?

Feel free to give specific (anonymous) examples.

4. Are there **barriers** to conducting more effective **therapy** with neurodivergent clients? Are there ways to overcome these?

SIP Appendix G: Coding Process Examples

Example subsection of early coding grouping and theme/subtheme earlier iteration



Earlier iteration of themes and subthemes

Barriers

Processing Difficulties
Communication difficulties
I'm the problem

Facilitators

Feeling understood
Developing coping strategies

Wider system impact

Power

We're different

Mental health AND neurodivergence
Unique needs

Initially, code clusters were grouped into barriers and facilitators of engagement. This grouping was likely overly guided by the research questions, serving to repeat the questions rather than involve deeper analysis. The interpretive methodological stance prompted a move beyond a simplistic problem-solution framework. Through reflection and discussion, it emerged that while a theme of ‘we are different’ felt substantial, capturing the different needs of neurodivergent service users, a distinct theme of ‘I feel different’ captured the different aspect of a felt sense of difference, which encompassed feeling understood when the group worked well. The idea that ‘I’m the problem’ came up in multiple interviews, and so this was subsumed by the idea that ‘I feel different’. This shift felt important, moving away from external categorisation to exploring the internal felt experience of feeling different, and how individuals make sense of this perception. ‘Knowing and expressing needs’ and ‘even if adaptation is offered, people can’t always take it’ emerged from the reasons

why people feel they are the problem, and feeling understood naturally fit better within this as a powerful consequence of BPT input when it worked well.

Discussion with the Expert by Experience highlighted among other things that communication and processing ‘differences’ would be a less pathologising way to conceptualise alternate ways of communicating and of processing information, without reiterating societal ideas that neurotypical is optimal. These then more logically fit within ‘we are different’, capturing unique needs of neurodivergent service users.

The initial ‘wider system impact’ was less analytical, and with further immersion into the data a strong sense of the duality of this emerged, which felt important to capture. While there is still some overlap between power and the wider system impact, conceptually these felt more appropriately separated, with power more heavily influencing felt sense of difference here-and-now, and past experiences within services shaping participants’ broader views and expectations of the mental health system. This led to the refined theme: ‘being different within the mental health system: wider system helps and hinders agency’, allowing for a more nuanced exploration of how the systemic context both supports and constrains neurodivergent service users’ experiences and sense of autonomy.

SIP Appendix H: Additional service user illustrative quotes

Theme	Subtheme	Supporting quotes
I feel different	Knowing and expressing needs	I did ask her loads of questions if I didn't understand what she meant (KF) Again, I would struggle with being able to explain myself, and get the words across correctly (OP)
	Even if adaptation is offered, people can't always take it	During the therapy I was like, if there's something that I don't understand, am I allowed to like, you know, raise my hand sort of thing and stop the group just so I could ask what that meant? Which I was obviously given the approval of all of that, you know, my assessor did say yes, we can support that and stuff, but then when it actually came to the time of doing it, I didn't, because especially with every like if I was struggling to understand a big word that was being said in the group and during the therapy. I felt like if I just kept raising my hand to say, what does that word mean? What does that word mean? It would be every like every other sentence. And then I just had that worry in my head of people are then going to judge me for not understanding. And then I'm the group's going to take even longer because I'm going to be stopping them every time just to explain what a word meant and things like that so I didn't do it as much (OP)
	Sense of acceptance afforded by group	We all shared some of our coping mechanisms as well (JX) Doing it tailored more at us autistics and having us autistics together means that helps us (KF) It felt really, really good, it felt really accepting and yeah, I think that I felt like I could have, umm meaningful conversations um and relate to people (EC)
	Powerlessness and lack of	I reach out to various MH services for help & then they're like ok well this is the quickest thing we can throw you into

	agency	is this group thing & I'll be like ok just 'cause it's like the soonest I can get into something (ES)
We are different	Neurodivergence makes accessing some parts of DBT harder	Is this something that a neurodivergent person could do? (OP) 'Cause DBT can be really hard for different neurodivergences (CS) Yeah, neurodivergence was part of it, I just, I found DBT difficult (CS)
	Processing and communication differences	Auditory processing issues, I think caused by the autism, so sometimes when people say things it'll like buffer in my brain or I just, it won't, like it'll be like in one ear and out the other (ES) My attention span is not that good (JX) The two sessions were good to like keep like people engaged like, not have too long between sessions (BM) I'm not very great at like, I can be kind of iffy about expressing myself verbally like, yeah, see I'm, I'm doing it now, I get like tongue tied with my words (ES) So I don't know if there's a way that I could I could have like, written it out in an e-mail or something before so something feel like because obviously the context was, I feel the context quite important for you guys to understand what I need, and maybe if that was like, a thing I could fill out before to give that clinician, clinician a bit of context (IW)
	Everyone's different	It's just like for me and I, you know, I know this wouldn't be the same for everyone (OP) I think having a chat just helps people. Not everyone's the same (KG)

		We're all autistic, if we have learning different learning curves. We're all different (KF)
Being different within the mental health system - wider system helps and hinders agency	Negative past experiences with MH services	GPs don't necessarily understand mental health, and then you go to mental health services and they don't understand autism. (ES) Is it because I'm autistic, they just don't want to help me because I'll be too hard to help? (OP) When I was younger, like no one used to help me, and it was hard to get any help at all. (KG)
	Support from family and other services is key	My older brother has been managing quite a lot of my bookings and stuff… my brother kind of took charge of all that (IW) I may have not actually fully gone through that assessment period and stuff on my own (DR) Yeah, she spoke on for me and sorted everything out and made sure that things got done because I just wasn't able to do it myself. (OP)

SIP Appendix I: Additional Staff Illustrative Quotes

Theme	Subtheme	Quotes
Uncertainty of diagnosis	Don't always know about or have a diagnosis	Assessment of the patients mental stated that could be in part related to anxiety around a first meeting, or in part related to neurodivergent presentation. (P6) Lack of confirmation if a patient has a diagnosis of ADHD and/or autism. (P6) Reading prior reports / referrals that mention autism / ADHD however as ASD is a disorder on a spectrum - limited information is given on where in the spectrum patient's lie (P10)
	Diagnosis can prevent change	Sometimes very concrete in thinking which makes more exploratory and psychodynamic therapy a challenge (P11) The client may be very wedded to particular diagnoses and may struggle to engage in a more psychological/alternative perspectives of the problem. I will try and bring some different perspectives/ understanding but this is not always possible and some clients will continue on wanting an intervention for a diagnosis they self-diagnosed themselves. (P1)
	Exploring the meaning and impact of diagnosis	Opportunity to reflect upon the meaning of diagnosis (P11) I particularly look for which aspect of the problem seems to be due to the neurodivergence rather than other factors although often factors are interdependent (P2) What is their relationships with their neurodivergence? (P2) I ask when they were diagnosed (if so) and how the diagnosis/ or the fact they were diagnosed late affects them, and if appropriate may incorporate this in their diagnosis, e.g. that a late diagnosis meant they were

		not adequately supported and potentially this also led them to internalise that they are not good enough. (P1)
Staff are willing but constrained	Thoughtful consideration of needs and adaptations	Would answer less complex questions: or split questions into smaller parts as the patient what their additional needs are and how we can support (P3) I have several neurodivergent clients and their needs are so different. (P4) Not comfortable in the space / chair- allow flexibility, I have one client who prefers to sit on the floor. (P4) Ensure you have a range of ways of sharing information, for example, easy read documents with pictures, plain English documents or social stories, to help prepare them for appointments. Having written information, reminding about appointments, being aware of the room, being clear in terms of the information which is being communicated, how its communicated, having easy reads, adapting diary cards, adapting chains within sessions, writing more notes for the patient etc. (P7) I often will call those who are neurodiverse a few times if they are running late/ forgot they had an assessment, and still go ahead with the assessment even if they attend late. I will check if they want to have someone else in the assessment to support them to get their views across. I may give an opportunity for a break. I may extend the session if possible or offer more than one session if it feels too overwhelming. I try and avoid metaphors/ check with them if they like metaphors and check their understanding. I explain it is ok for them to look away from the camera/ from me and not have to make eye contact. I

		explain they can also fidget/ get up/ move. I ask if they have special interests to enable engagement (P1)
	Limited resources	Limited access to more flexible environments where reasonable adjustments can be made to meet the needs of this patient group (P6) More one to one options, however limited in staff (P7) Unsure if we would be allowed as a service to offer more, but shorter, sessions. (P9)
	Adapting environment to client, or client to environment?	If processing speed is quite slow, it may be difficult to complete as much work in therapy as perhaps would be able to with someone who is neurotypical (P9) Time limits to individual work (P3) What's allowable, possible in the service I am in (P2)
Importance of a paced, flexible approach	Allowing extra time	*Takes time to sit with and think about: maybe why assessments are often helped over two or three weeks.* (P3) shorter sessions (P3) Taking time to build relationships - extending assessments. (P4) length of time in session- with some of my clients I have introduced a break part way through the individual session - this has worked well. (P4) Our DBT groups are 2 hours long and my clients express difficulty with concentration / sitting still for this length of time. Although we permit clients to move around / have fidget devices etc, 2 hours is a long time for an appointment. (P4) Being more flexible with lateness, being flexible with having to go over time if needed). (P8)
	Assessment of needs continues	They will be the expert in knowing what has worked or not worked for them. If this feels unclear to allow

	from referral through therapy	space to keep checking in on this (P4) I think asking what we can think about for the assessment to feel manageable has been helpful to give permission for any adaptations I might not have thought about to be raised. (P5) I try to ask about whether they may need any adaptations and if they need breaks to let me know. (P8)

SIP Appendix J: Psychology and Psychotherapy: Theory Research and Practice Journal Submission Guidelines

Sections

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
7. Publication Process After Acceptance
8. Post Publication
9. Editorial Office Contact Details

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

New submissions should be made via the **Research Exchange submission portal**. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the “My Submissions” button. For technical help with the submission system, please review our FAQs or contact **submissionhelp@wiley.com**.

All papers published in the *Psychology and Psychotherapy: Theory Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

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• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
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- The full names of the authors;

- The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
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- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
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All articles must include Practitioner Points – these are 2-4 bullet point with the heading ‘Practitioner Points’. They should briefly and clearly outline the relevance of your research to professional practice.

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- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

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TDRP Appendix A: Practitioner Points

- Integrating a voice hearer identity into one's broader coherent self-concept may be important for wellbeing, but is unlikely to shift through brief, one-off intervention videos.
- Brief lived-experience videos may enhance voice hearer identity in some; practitioners should consider facilitating access to other voice hearers, including through videos, in-person and online groups and individual interactions to enhance a positive sense of self as a voice hearer.
- The process of identity integration among voice hearers may require individualised approaches, allowing for personal reflection.
- Individuals may have contrasting responses to hearing others' stories, with potentially negative effects on those with high voice severity, which should be considered when offering groups and peer support.

TDRP Appendix B: Script and YouTube link for Intervention video

Script

P1:

Do you identify as a voice hearer?

Yes, I like it. When I first got a diagnosis, I thought ‘that’s it’, I can’t get better, I probably won’t be able to work. It felt like a grey cloud over all the other parts of my identities. But having the label of a voice hearer feels much more neutral to me. Some people also like terms like shaman or clairvoyant but to me, voice hearing feels like a middle ground between sensationalising in a positive or a negative way. It’s neutral. Maybe I’ll find another term in the future that better captures all my experiences, but for now it’s good.

Over time, being a voice hearer has become a smaller part of me, there are so many other things that I am. I am a friend, a daughter, a sister, and a kind person. My identity is always evolving. My mental health experiences have made me more understanding of people, more open, I am sensitive and empathetic to others. Having extra-sensory experiences has given me a different perception of the world, I am more in touch with my spiritual side.

I found it helpful to share my experiences online, it felt like there was less at stake and I can be less selective with who I share with or what I share. Sometimes you get negative feedback, like when I posted saying I don’t take medication, I had people telling me I should be on meds, but I’m happy off meds and I feel like other people’s opinions matter less online. Sometimes I might say SMI, serious mental illness,

instead of saying my exact diagnosis if I want to communicate the severity without the specific assumptions my diagnosis might come with. You don't have to tell people outright if it doesn't feel safe. I also feel more comfortable sharing that I'm a voice hearer with other people who are voice hearers, and I make that feel safer by saying "I see what you're talking about" or "I think we've been through similar things".

Over time the Hearing Voices Network has helped me to accept the voices as a part of me. I now think that hearing voices is ok, even though it might be scary at times, you can still do anything you want, it can be a positive side of you. I am more than just my voices.

P2:

Do you identify as a voice hearer?

I do hear voices, but I usually identify as someone with psychosis because when I am struggling with my mental health, I feel like the term psychosis validates how severe I feel when things are bad. I know some people don't like the medicalisation of it, but I have found this helpful.

How did it become a part of your identity?

I think it took time and wasn't immediate – it wasn't when I first experienced the voices, or when I first got a diagnosis. It developed through working in research as someone with lived experience. Being able to apply my experiences to make research better, being able to share my perspective, was helpful. I find my psychosis has given me skills, like I'm good at spotting connections at work – it can be a problem with my delusions but useful for noticing patterns. Even applying skills from

therapy like finding evidence has helped me across the board. Sometimes though, it's difficult to separate being a researcher and being a patient.

I also started writing a blog about my experiences of hearing voices, and this meant I could share what I was going through and helped me to process it, as well as helping other patients and carers. Having that space helped me to integrate my experiences into my sense of who I am. After a while I decided to stop being anonymous, and it now feels like a big part of who I am. I think this changed the way I interact with it. In some ways it limits what I post but I think that's a big part of having voices as part of your identity, it's always important to have control over aspects of my lived experience that I make visible or share with other people. And my family were supportive, they told me about TV programmes about mental health that they'd been watching, and this helped made it feel like it was acceptable to talk about with them.

Being a part of different social groups has been helpful for me, they change how I think of myself and have helped me see myself in a more positive light and have actually helped the voices be easier to deal with.

I do feel like my identity as someone with psychosis is fully integrated into me and who I am, but even so, it still matters to me that I only share if and when its safe to do so. If I'm meeting someone new, I kind of work it out by bringing up mental health-related topics like "Oh did you see that program about mental health on TV?" or 'have you read that book?' to try and work out how they're gonna respond.

P3

Do you identify as a voice hearer?

When the voices first started, I isolated myself from everyone around me. I stopped going outside, stopped speaking to my family. I shut myself away in my room

because I felt so paranoid. But then I started speaking to my keyworker, and when I felt a bit better she suggested I start going to a local Hearing Voices group – I remember being so scared the first time, but when I got there I found it helpful to hear other people talk about their experiences. In the weeks after, I started to open up about my voices, and just seeing people nodding around me, agreeing, it was actually pretty powerful for me. I started building my life back up over the years – I started going to the shop just to practice being out and about, my keyworker helped me to get a voluntary job, I went back to my local 5-a-side. It wasn't easy but this helped me to see that maybe I can trust people, maybe I deserve to have a life.

Before I'd told anyone, I felt like I was carrying around this heavy secret. One of the reasons I kept away from socialising at the start was because I used to worry about whether I would respond to voices in front of people. I told John at my 5-a-side, just gave him the heads up that I might sometimes respond to voices and that its not something to worry about. He was really nice about it, said 'thanks for telling me mate' and it helped me to relax, it actually made the voices easier to tolerate and at football he'll come over and just give me a thumbs up and see if I'm ok. I don't tell everyone, I test the waters and look for signs that they'll be understanding, but I've accepted it as a part of me, why should I be ashamed? Why shouldn't I have a full and happy life? The voices I hear, the colleague I am at work, the man I am with my family, they're all a part of me.

YouTube video is accessible here (this video is unlisted and so is only accessible via this link): https://www.youtube.com/watch?v=cKGZIKvBbJ0

TDRP Appendix C: Research Poster and Participant Sources

C.1 Research Poster

C2. Participant recruitment sources

Participant Sources			
Source	**Counts**	**% of Total**	**Cumulative %**
Reddit	8	8.5%	8.5%
Forum	5	5.3%	13.8%
Unknown	3	3.2%	17.0%
McPin Foundation	1	1.1%	18.1%
Facebook	45	47.9%	66.0%
Hearing Voices Networks	10	10.6%	76.6%
TikTok	17	18.1%	94.7%
Instagram	5	5.3%	100.0%

TDRP Appendix D: Debrief

Dear Volunteer,

Thank you for taking part in this research study. This message is intended for anyone taking part in the study. Our moods and stress levels can change from day to day. However, for some people their mood may remain low, irritable, or changeable for some time. If this applies to you, I would like to point out that there are several sources of advice or help which are free and readily available to you and which may prove useful. Specifically, these include:

1. Your General Practitioner, who can also refer you to specialist mental health support services including access to psychological therapy.

2. NHS 111 – through this number you can access your local mental health crisis line 24 hours a day, 7 days a week, for people of all ages.

3. The Samaritans helpline on 116 123 or via email at jo@samaritans.org (available 24/7)

4. Rethink, a British charity specialising in mental health who offer advice and local groups https://www.rethink.org/

5. Hearing Voices Network, a national charity who offer information and signposting to local Hearing Voices Groups info@hearing-voices.org

If you would like additional information, or a confidential discussion with a senior member of the research team, please contact either Roisin Quinn or Lorna Hogg using the contact details at the top of the page. Please be advised that it may take up to 48 hours for a response.

Roisin Quinn

TDRP Appendix E: Ethical Approval Letter CUREC

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Lorna Hogg & Roisin Quinn
Oxford Institute for Clinical Psychology Training and Research (OxICPTR)
Isis Education Centre
Warneford Hospital
Oxford

26 September 2024

Dear Lorna and Roisin,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R94296/RE001

Study title: The effectiveness of a lived experience video about voice hearer identity on the social identity integration and wellbeing of voice hearers

Short title: Targeting social identity integration in voice hearers

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **26th September 2024** until **25th March 2026.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

Amendments
Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely
DocuSigned by:
Leah Butts
Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

TDRP Appendix F: Measures

E1. State adapted Paranoia Checklist, Brief version

REDACTED

E2. Hamilton Program for Schizophrenia Voice Hearing Questionnaire (Van Lieshout & Goldberg, 2007)

REDACTED

E3. Adapted In-Group Identification Scale (Leach et al., 2008), adapted in line with Hogg et al. (2023)

REDACTED

E4. Adapted version of Multicultural Identity Integration Scale (MULTIIS) – Integration subscale

REDACTED

E5. State Identity measure

REDACTED

E6. State Identification measure

[First image illustrates different positions on the scale, second illustrates accurate labels]

REDACTED

E7. Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS)

REDACTED

TDRP Appendix G: Additional Demographic Information

Demographic		Group	Counts	% of Total
Age	**18 to 24**	**Control**	11	11.7%

Demographic		Group	Counts	% of Total
		Intervention	12	12.8%
	25 to 34	Control	9	9.6%
		Intervention	9	9.6%
	35 to 44	Control	5	5.3%
		Intervention	9	9.6%
	45 to 54	Control	8	8.5%
		Intervention	8	8.5%
	55 to 64	Control	8	8.5%
		Intervention	4	4.3%
	65 to 74	Control	2	2.1%
		Intervention	2	2.1%
	75 to 84	Control	3	3.2%
		Intervention	2	2.1%
	85 and over	Control	0	0.0%
		Intervention	2	2.1%
Gender	Female	Control	29	30.9%
		Intervention	26	27.7%
	Female (transgender)	Control	1	1.1%
		Intervention	0	0.0%
	Male	Control	13	13.8%
		Intervention	14	14.9%
	Non-binary	Control	1	1.1%
		Intervention	4	4.3%
	Transgender (unknown)	Control	2	2.1%
		Intervention	4	4.3%
Ethnicity	Asian British: Indian	Control	0	0.0%
		Intervention	1	1.1%
	Asian British: Pakistani	Control	0	0.0%

Demographic		Group	Counts	% of Total
		Intervention	1	1.1%
	Black British: African	Control	1	1.1%
		Intervention	0	0.0%
	Black British: Other	Control	1	1.1%
		Intervention	1	1.1%
	Mixed ethnic groups: White and Black	Control	0	0.0%
		Intervention	1	1.1%
	Mixed ethnic groups: White and Asian	Control	1	1.1%
		Intervention	0	0.0%
	White: English, Welsh, Scottish, Northern Irish or British	Control	36	38.3%
		Intervention	36	38.3%
	White: Irish	Control	2	2.1%
		Intervention	2	2.1%
	White: Other	Control	5	5.3%
		Intervention	6	6.4%
Highest level of education completed	Doctorate degree [e.g. PhD]	Control	3	3.2%
		Intervention	0	0.0%
	Higher Education Diploma [e.g. Certificate of Higher Education; Level 4 Diploma]	Control	2	2.1%
		Intervention	12	12.8%
	Postgraduate university degree [e.g. MA; MSc; PGCE]	Control	4	4.3%
		Intervention	8	8.5%
	Primary School	Control	2	2.1%
		Intervention	3	3.2%
	Secondary School or equivalent [e.g. GCSE, NVQ, Junior Cert]	Control	6	6.4%

Demographic		Group	Counts	% of Total
		Intervention	6	6.4%
	Sixth Form College or equivalent [e.g. A-Level; BTEC; Bac; I.B., Leaving Cert]	Control	15	16%
		Intervention	9	9.6%
	Undergraduate university degree [e.g. BA; BSc]	Control	14	14.9%
Marital status		Intervention	10	10.6%
	Divorced	Control	4	4.3%
		Intervention	5	5.3%
	Married or in a domestic partnership	Control	11	11.7%
		Intervention	17	18.1%
	Prefer not to say/Other	Control	3	3.2%
		Intervention	1	1.1%
	Single (never married)	Control	28	29.8%
		Intervention	25	26.6%
Employment status	Full-time employed	Control	6	6.4%
		Intervention	7	7.4%
	Part-time employed	Control	5	5.3%
		Intervention	8	8.5%
	Retired	Control	4	4.3%
		Intervention	3	3.2%
	Self-employed	Control	3	3.2%
		Intervention	1	1.1%
	Student	Control	5	5.3%
		Intervention	7	7.4%
	Unable to work	Control	17	18.1%
		Intervention	16	17.0%

Demographic		Group	Counts	% of Total
	Unemployed	**Control**	6	6.4%
		Intervention	6	6.4%
Previously sought help for mental health	**No**	**Control**	5	5.3%
		Intervention	2	2.1%
	Yes	**Control**	41	43.6%
		Intervention	46	48.9%
Previously hospitalised for mental health (Y/N)	**No**	**Control**	19	20.2%
		Intervention	20	21.3%
	Yes	**Control**	27	28.7%
		Intervention	28	29.8%
Has psychosis type diagnosis (including schizophrenia, schizoaffective disorder/bipolar)	**Yes**	**Control**	24.5%	24.5%
		Intervention	23.4%	23.4%
	No	**Control**	24.5%	24.5%
		Intervention	27.7%	27.7%

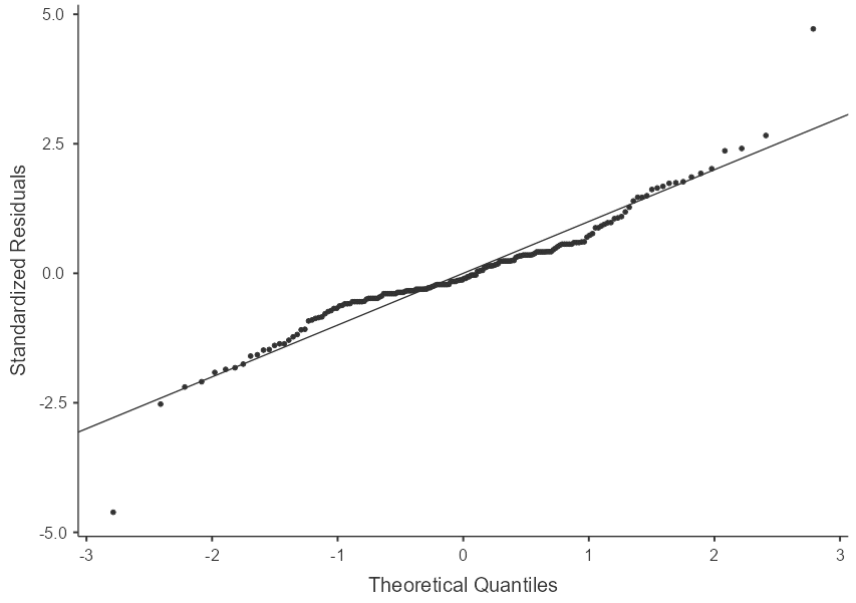
TDRP Appendix H: Residual Plots

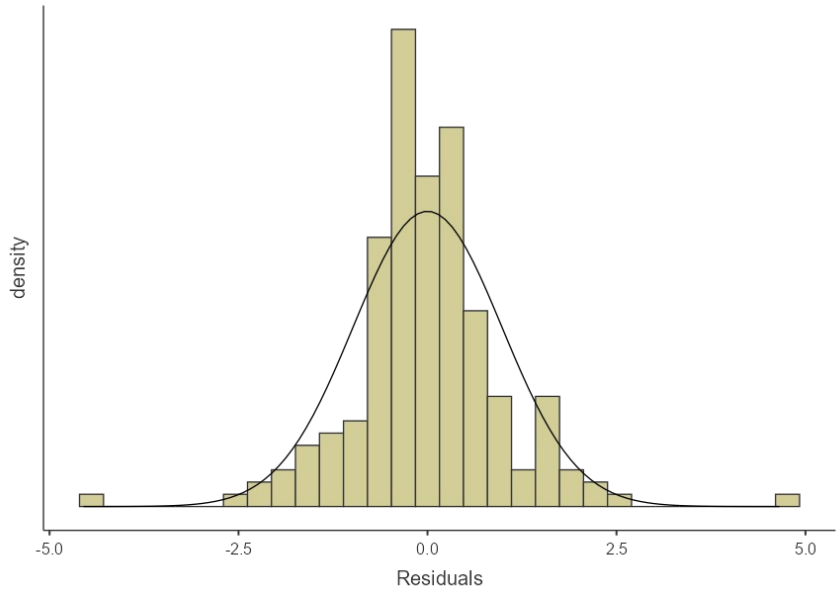
Hypothesis One Assumption Checks

Test for Normality of residuals

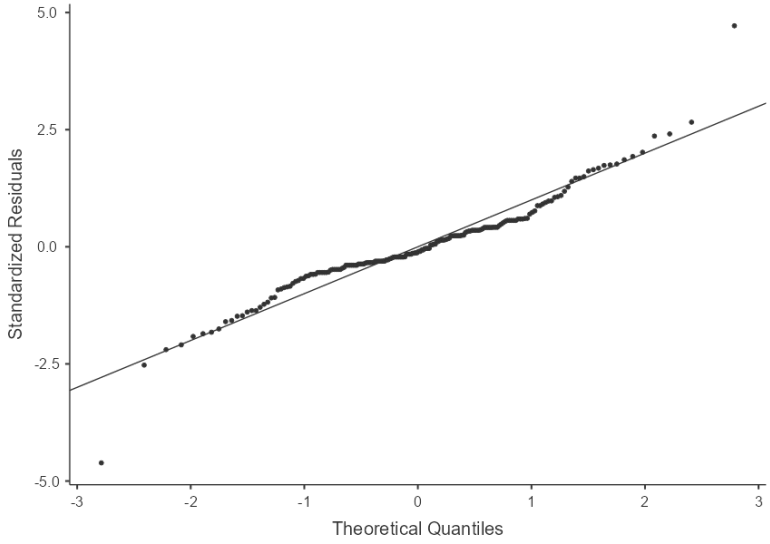
Test	Statistics	p
Kolmogorov-Smirnov	0.108	0.025
Shapiro-Wilk	0.937	<.001

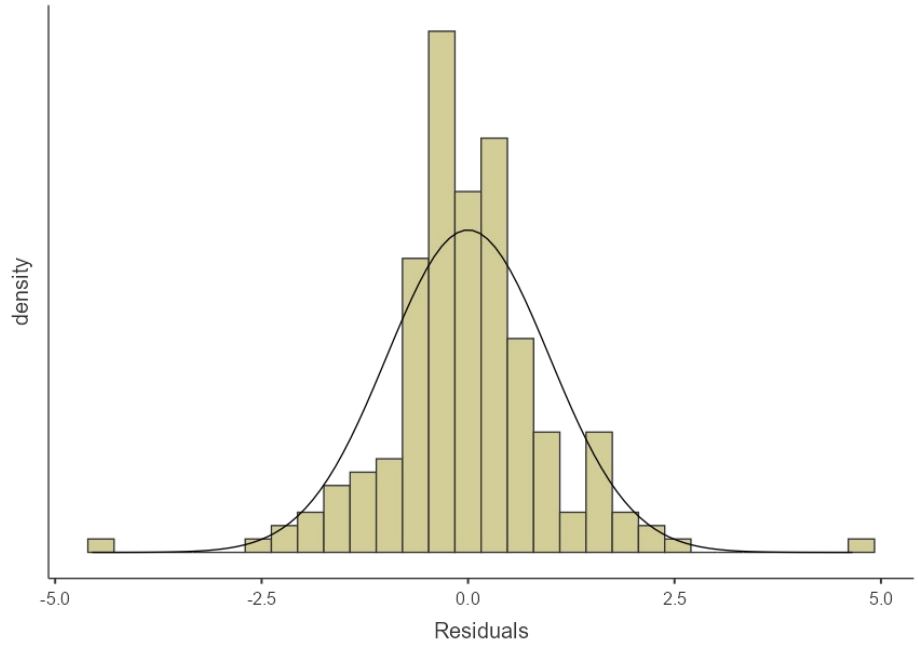
Note. ties should not be present for the one-sample Kolmogorov-Smirnov test





Identity Exploratory Analysis Assumption Checks





Hypothesis Two Assumption Checks

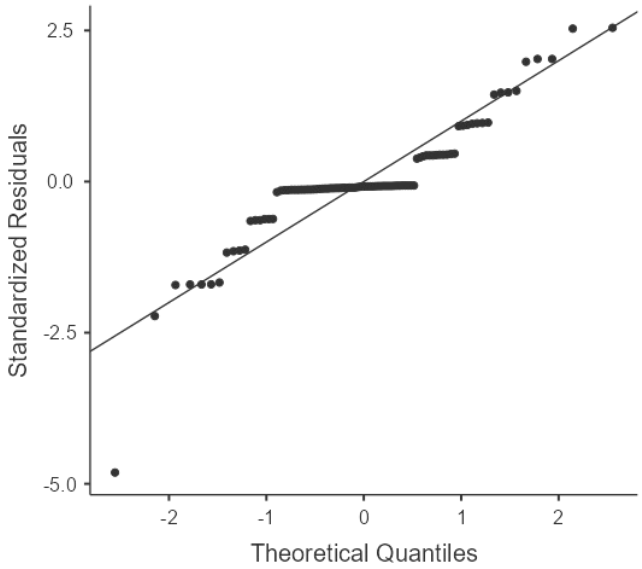
Test for Homogeneity of Residual Variance

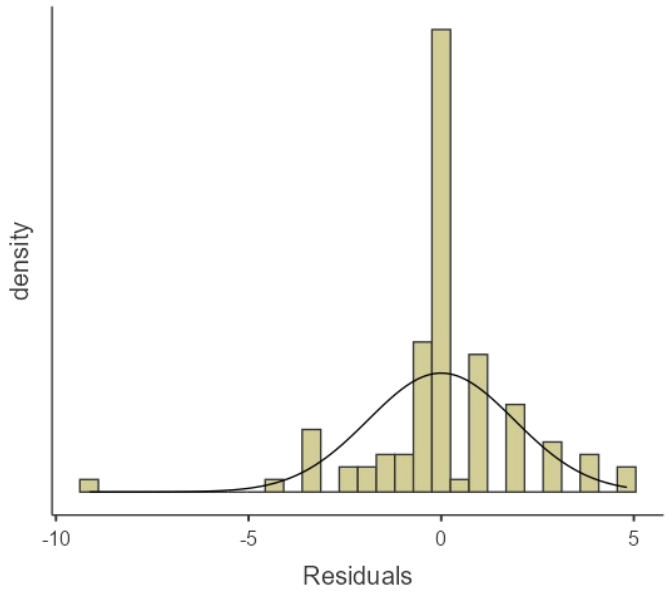
Test	Statistics	df1	p
Breusch-Pagan Test	0.689	1	0.406

Test for Normality of residuals

Test	Statistics	p
Kolmogorov-Smirnov	0.250	<.001
Shapiro-Wilk	0.851	<.001

Note. ties should not be present for the one-sample Kolmogorov-Smirnov test





Wellbeing/integration exploratory analysis

Test for Homogeneity of Residual Variance

Test	Statistics	df 1	p
Breusch-Pagan Test	9.55	7	0.216

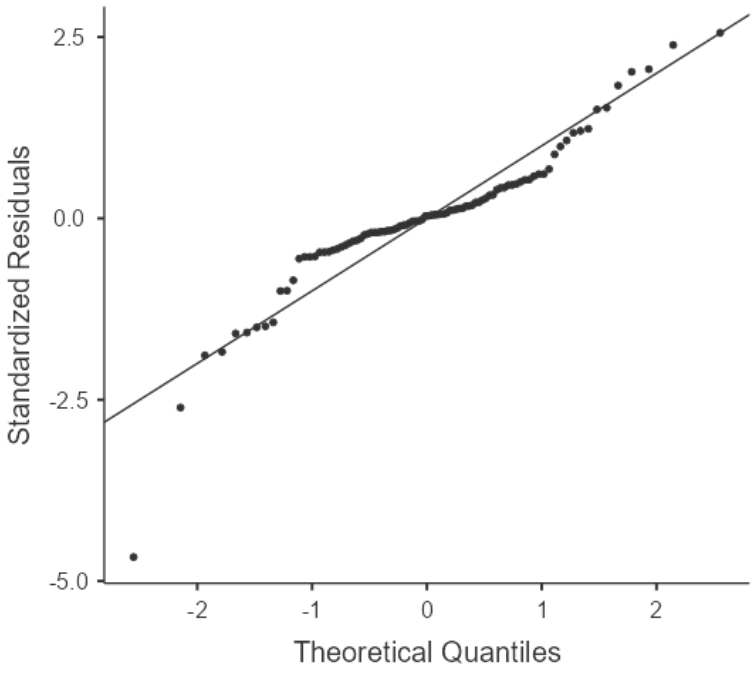
Test for Normality of residuals

Test	Statistics	p
Kolmogorov-Smirnov	0.106	0.613
Shapiro-Wilk	0.973	0.337

Collinearity statistics

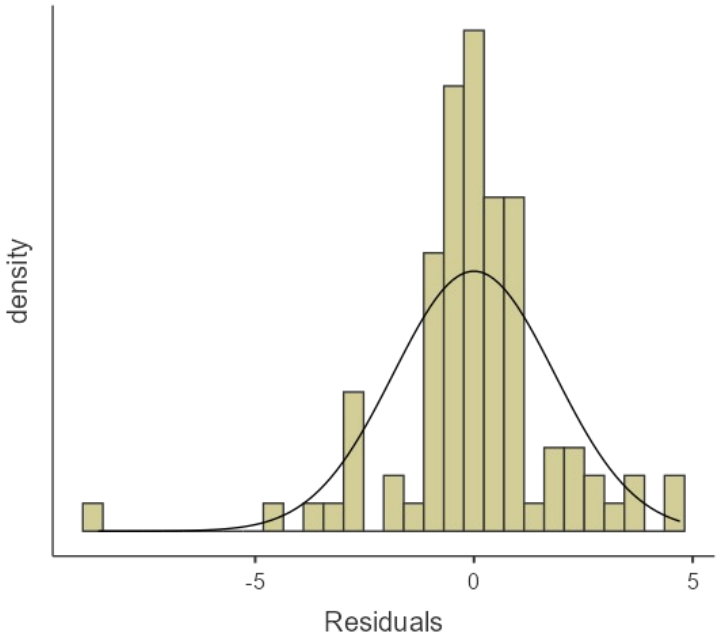
Term	VIF	Tolerance
ParanoiaTotal	2.01	0.498
HPSVQTotal	1.92	0.520
VHIdentityFullMeasureTotal	2.00	0.501
IntegrationFullMeasureTotal	1.74	0.575
WHONoTotalPre_main	2.28	0.438
Engaging0_100	2.44	0.410
Resonance0_100	2.18	0.459

Q-Q Plot



Residual histogram

Residual histogram


density
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Residuals

TDRP Appendix I: Journal Submission Guidelines

Sections

10. Submission
11. Aims and Scope
12. Manuscript Categories and Requirements
13. Preparing the Submission
14. Editorial Policies and Ethical Considerations
15. Author Licensing
16. Publication Process After Acceptance
17. Post Publication
18. Editorial Office Contact Details

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

New submissions should be made via the **Research Exchange submission portal**. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the “My Submissions” button. For technical help with the submission system, please review our FAQs or contact **submissionhelp@wiley.com**.

All papers published in the *Psychology and Psychotherapy: Theory Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will

be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

Preprint policy:

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological and social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
- high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in *Psychology and Psychotherapy: Theory, Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 8000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

Brief-Report COVID-19

For a limited time, the *Psychology and Psychotherapy: Theory, Research and Practice* are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

Free Format Submission

Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://wiley.atyponrex.com/journal/PAPT** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;

- The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our **Author Services** site.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading ‘Practitioner Points’. They should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the LaTex Main Document should be uploaded as a “LaTeX Supplementary File.”

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (intro/methods/results/conclusion);
- Up to seven keywords;
- Practitioner Points Authors will need to provide 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);
- Statement of Contribution.

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language. The BPS's Inclusive Language Guidance provides a set of recommendations to support the key principles of inclusivity in writing.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available **here.** In particular, we encourage authors to consult Wiley's best practice tips on **Writing for Search Engine Optimization**.

Article Preparation Support: **Wiley Editing Services** offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for **Preparing Your Article** for general guidance and the **BPS Publish with Impact infographic** for advice on optimizing your article for search engines.

ECR Best Paper Award

The **BPS Early Career Researcher Best Paper Award** is open to researchers and practitioners who completed their highest degree no more than five years ago. Please read full terms and criteria before applying. Those who wish to apply can opt-in to the question when submitting their manuscript for peer review.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double-anonymous) peer review. Please ensure that any information which may reveal author identity is anonymized in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, please read **the terms and conditions of submission** and the **declaration of competing interests**.

We aim to provide authors with a first decision within 90 days of submission.

Further information about the process of peer review and production can be found in '**What happens to my paper?**' **Read** Wiley's policy on the confidentiality of the review process.

Appeals Procedure

Authors may appeal an editorial decision if they feel that the decision to reject was based on either a significant misunderstanding of a core aspect of the manuscript, a failure to understand how the manuscript advances the literature or concerns regarding the manuscript-handling process. Differences in opinion regarding the novelty or significance of the reported findings are not considered as grounds for appeal.

To raise an appeal against an editorial decision, please contact the Editor who made the decision in the first instance using the journal inbox, quoting your manuscript ID number and explaining your rationale for the appeal. Appeals are handled **according to the procedure recommended by COPE**. If you are not satisfied with the

Editor(s) response, you can appeal further by writing to the BPS Knowledge & Insight Team by email at **Academic.Publications@bps.org.uk**. Appeals must be received within two calendar months of the date of the letter from the Editor communicating the decision. The BPS Knowledge and Insight Team's decision following an appeal consideration is final.

If you believe further support outside the journal's management is necessary, please refer to **Wiley's Best Practice Guidelines on Research Integrity and Publishing Ethics** or contact **Academic.Publications@bps.org.uk**.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

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