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EMMA J IZON

1405183

Harris Manchester College

The University of Oxford



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List of Abbreviations

APA: American Psychiatric Association
ANCOVA: Analysis of Covariance
ANOVA: Analysis of Variance
ARMS: At-Risk Mental State
CBTp: Cognitive Behavioural Therapy for Psychosis
CMHT: Community Mental Health Team
EIP: Early Intervention Psychosis
EUPD: Emotionally Unstable Personality Disorder
FEP: First Episode Psychosis
FI: Family Intervention
GHQ: General Health Questionnaire
IPA: Interpretative Phenomenological Analysis
LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer, plus individuals from other minority sexual groups
MH: Mental Health
NHS: National Health Service
NICE: National Institute for Health and Care Excellence
No.: Number
OA: Older Adults
PDSA: Plan-Do-Study-Act
PT: Psychological Therapies

PTSD: Post-Traumatic Stress Disorder

PwFEP: Persons with First Episode Psychosis

QI: Quality Improvement

QoL: Quality of Life

RCT: Randomised Control Trial

SMI: Severe Mental Illness

SOPEP: Siblings of People with Experiences of Psychosis

SOPS: Siblings of People with Schizophrenia

SZ: Schizophrenia

TAO: Trans and Other

Published Work

This thesis is submitted in alternative format with three papers. To maximise dissemination, the critical review of literature and service improvement project papers have been submitted to peer-reviewed journals and the theoretical driven (main) research project will be submitted to a journal.

Critical Review of Literature is under review at *Clinical Psychology & Psychotherapy.*
Service Improvement Project is under review at *Nursing Older People.*
The Theoretical Driven (Main) Research Project will be submitted to *Psychology of Sexual Orientation and Gender Diversity*.

Abstract

Systematic Review of the Literature: The Psychosocial Stressors of Siblings of People with Experiences of Psychosis (SOPEP): A Systematic Narrative Review across Cultures.

Background This study aimed to synthesise the psychosocial stressors of siblings of people with experiences of psychosis (SOPEP). Understanding the specific needs of siblings across diverse cultures would help mental health services to provide culturally specific psychosocial family and sibling-centred support. This may result in improved relationships between families, better psychosocial wellbeing for siblings, and better outcomes for patients. **Methods** Following PRISMA guidelines, a systematic review was conducted to explore the psychosocial stressors of SOPEP. Six databases were utilised to identify literature of qualitative methodology. **Results** Twenty-two studies were included that investigated the Psychosocial Stressors of SOPEP. SOPEP's experiences were influenced by various stages: individual factors, social factors, physical and macro-level environments. Six key components contributed to SOPEP's psychosocial stressors and facilitated or hindered their intentions, behaviours, and experiences of caregiving. These were the SOPEP's beliefs about psychosis, caregiving beliefs, family and cultural values, personality traits, pragmatic challenges, and access to resources. **Conclusions** Globally, SOPEP and families may benefit from their involvement in family interventions and individual support that facilitates caregiving and acknowledges their responsibilities, resources, psychosocial needs and emotional experiences.

Key words: *psychosis; psychosocial; severe mental illness; siblings; family; qualitative.*

Abstract

Service Improvement Project: Understanding Barriers to Receiving Psychological Intervention for Older Persons in the Community, who Experience Distressing Hallucinations.

The NHS 10-year plan aims to address inequalities in service provision, provide appropriate mental health support to all ages, and upskill healthcare professionals working in mental health community services. This research involved three phases: *Phase 1*– a clinical audit, *Phase 2*– a survey exploring the perceptions of mental health professionals in the service, and *Phase 3*– the Plan-Do-Study-Act improvement strategy. Between 2015-2021, only 6% of older persons with experiences of hallucinations were referred to psychological services, of whom only 1.3% received psychological interventions. Healthcare professionals within the community mental health team felt a combined psychological and pharmaceutical approach was most helpful for patients but were less confident referring patients to psychological services and discussing these benefits. Recommendations for services include utilising assessment tools to assess hallucinations in older persons, collaborating with third sector organisations and access to further training for healthcare professionals.

Key words: *older adults; hallucinations; psychosis; healthcare professionals; psychological intervention*

Abstract

The Theoretical Driven (Main) Research Project: Investigating Sexual Orientation Concealment and Psychological Health in an Ethno-religious LGBTQ+ Jewish Group and Non-religious LGBTQ+ Group.

Background An individual's relationship with sexuality and religion may be complex, particularly when these principles conflict. According to Minority Stress Theory, people from minority groups (e.g., religion, sexuality) can experience excess stress, which may contribute towards psychological distress. LGBTQ+ people living in more stigmatising environments may therefore seek to conceal their sexual orientation and this can negatively impact their mental health. **Aim** This study looked to investigate sexual identity concealment in an ethno-religious Jewish LGBTQ+ population. **Methods** The experiences of concealment of Jewish LGBTQ+ were compared with a non-religious LGBTQ+ group. Information about participants' concealment behaviour and their psychological health was collected, alongside participants' Jewish identity. **Results** Concealment was higher in the non-religious LGBTQ+ group compared to the Jewish LGBTQ+ group, although overall mental health was significantly poorer in the Jewish group. The study did not find concealment to predict mental health. Within the Jewish group, LGBTQ+ individuals who identified as more culturally and religiously Jewish concealed more. **Discussion** Other processes may better predict mental health for this population. Minority Stress Theory suggest this may be due to proximal stressors, such as expectations of rejection or internalised homophobia. Meanwhile, the importance of Jewish cultural and family values over religious practice may explain participants' openness about their sexual orientation. There is a need for qualitative research to explore the impact on and purpose of concealment for Jewish LGBTQ+. There is also a need for more quantitative research to better understand the experiences that contribute towards mental health difficulties for LGBTQ+ Jews and how services can meet this need.

Key words: *identity, concealment, minoritised groups, Jewish, sexuality, LGBTQ+*

Chapter 1

Study 1 - Systematic Review of the Literature: The Psychosocial Stressors of Siblings of People with Experiences of Psychosis (SOPEP): A Systematic Narrative Review across Cultures.

Candidate: Emma Izon, Trainee Clinical Psychologist, The Oxford Institute of Clinical Psychology Training and Research.
Email: emma.izon@hmc.ox.ac.uk

Internal Supervisor: Dr Matthew Knight, Senior Admissions Tutor and Clinical Tutor, The Oxford Institute of Clinical Psychology Training and Research, The Oxford Centre for Psychological Health, Oxford Health NHS Foundation Trust.
Email: matthew.knight@hmc.ox.ac.uk

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Proposed Journal: This manuscript is under review at *Clinical Psychology & Psychotherapy.* This journal has been selected due to its focus on a range of mental health problems, including schizophrenia and other psychoses. Research using similar methodology to this paper and relating to psychosis across the lifespan and barriers to access have been published by this journal. This journal adheres to APA referencing style, for details, please see https://onlinelibrary.wiley.com/page/journal/10990879/homepage/forauthors.html

Acknowledgements: This work was supported by the Oxford Institute for Clinical Psychology Training and Research. No funding was sought for this project. A second trainee on the course, Jerica Radez (JR), was involved in the project as a collaborator to perform reliability checks. The authors note no conflicts of interest.

Title: The Psychosocial Stressors of Siblings of People with Experiences of Psychosis (SOPEP): A Systematic Narrative Review across Cultures.

Abstract

Background This study aimed to synthesise the psychosocial stressors of siblings of people with experiences of psychosis (SOPEP). Understanding the specific needs of siblings across diverse cultures would help mental health services to provide culturally specific psychosocial family and sibling-centred support. This may result in improved relationships between families, better psychosocial wellbeing for siblings, and better outcomes for patients. **Methods** Following PRISMA guidelines, a systematic review was conducted to explore the psychosocial stressors of SOPEP. Six databases were utilised to identify literature of qualitative methodology. **Results** Twenty-two studies were included that investigated the Psychosocial Stressors of SOPEP. SOPEP's experiences were influenced by various stages: individual factors, social factors, physical and macro-level environments. Six key components contributed to SOPEP's psychosocial stressors and facilitated or hindered their intentions, behaviours, and experiences of caregiving. These were the SOPEP's beliefs about psychosis, caregiving beliefs, family and cultural values, personality traits, pragmatic challenges, and access to resources. **Conclusions** Globally, SOPEP and families may benefit from their involvement in family interventions and individual support that facilitates caregiving and acknowledges their responsibilities, resources, psychosocial needs and emotional experiences.

Key words: *psychosis; psychosocial; severe mental illness; siblings; family; qualitative.*

Abbreviations*: Siblings of People with Experiences of Psychosis (SOPEP); At-Risk Mental State (ARMS); First Episode Psychosis (FEP); Severe Mental Illness (SMI).*

Introduction

"Sibling relationships - outlast marriages, survive the death of parents, resurface after quarrels that would sink any friendship. They flourish in a thousand incarnations of closeness and distance, warmth, loyalty and distrust." Erica E. Goode

This paper begins by describing the term "caregiving", acknowledging those who undertake a caring role. Subsequently, the term "psychosis" and experiences along the psychosis spectrum will be introduced. The authors consider cultural differences both within populations and between countries when reviewing the literature on psychosis. A summary of the key findings within psychosis literature will provide context for studying Siblings of People with Experiences of Psychosis (SOPEP). Limitations from an earlier review will be explored, followed by the research aims of the current study.

Caregiving

A carer is someone who provides support to an individual, which includes family members living with or providing support from a distance (NHS, 2017). Caring for someone experiencing mental health difficulties may involve practical help, personal care and/or emotional support (McCann et al., 2011). Providing support may impact carers' emotionally, physically, socially, and/or financially, both positively and negatively (Shirashi & Reilly, 2019). The level of multifaceted strain perceived by caregivers over time is known as caregiver burden (Liu et al., 2020). In this paper, siblings have been referred to as carers, yet it is recognised some may not consider themselves a carer (BPS, 2021).

Psychosis

Psychosis is a set of experiences rather than a diagnosis. Symptoms include upsetting beliefs and experiences (e.g., that someone is following you), perceptual experiences that others do not share (e.g., hearing voices), confused thinking or speech (NICE 2014; LIKEMIND, 2019). Other symptoms may include a loss of motivation, energy or interest in things, feeling flat, struggling to engage with work/school and disengaging from friends and/or family (LIKEMIND, 2019). Psychosis conditions affect more than 20 million people worldwide (James et al., 2018), emerging typically in adolescence and early adulthood (McClellan, 2018). Psychosis may be an extension of our anxieties and occur when people experience trauma or extreme stress (LIKEMIND, 2019). The DSM-5 classification for primary

psychotic disorders emphasises that these conditions occur along a spectrum, with schizoid (personality) disorder and schizophrenia defining its mild and severe ends, respectively (Arciniegas, 2015). More recently, there has been a focus in the literature on prevention and early intervention, moving from chronic conditions (e.g., schizophrenia; Severe Mental Illness) to early psychosis experiences (e.g., First Episode Psychosis, FEP; the At-Risk Mental State, ARMS). The term 'ARMS' describes a state that confers a high but not inevitable risk of developing a psychotic condition (McGorry & Singh, 1995).

In the process of deinstitutionalisation, the focus of rehabilitation and treatment has shifted to the community, relying on families to care for their ill family member (Kritzinger et al., 2011). A high proportion of people with experiences of psychosis live at home and are supported by their families (Izon et al., 2019). The literature recommends family interventions for people experiencing symptoms of psychosis (Claxton et al., 2017; Varghese et al., 2020). Benefits may include reduced relapse and re-hospitalisation rates and improved prognosis for family members (Claxton et al., 2017; Camacho-Gomez & Castellvi, 2020). Families themselves gain a sense of empowerment, enhanced stigma coping skills and can facilitate patient engagement (Ben-David et al., 2019; Izon et al., 2020).

Cultural Differences

The literature exploring family members' experiences originate predominantly from Western cultures, with few studies including Black and Minority Ethnic samples, who are overrepresented in rates of psychosis in many regions (Edge et al., 2016). Cultural differences may exist and influence family members' perceptions and management of psychosis, and caregiving behaviours. Considering diverse cultural traditions and values is essential to understanding families' experiences and providing acceptable and effective culturally adapted interventions (Rathod et al., 2017).

Culture decides which behaviours are acceptable and open to criticism, with variations in levels of affection and concern shown by family towards individuals with experiences of psychosis. Explanatory models of psychosis may include supernatural beliefs about the aetiology of the illness, seeing mental illness through a spiritual-social model, rather than biomedical. In certain cultures, people with symptoms of psychosis and their families may experience social exclusion from employment (economic exclusion), denied legal rights to

vote, marry or own land (political exclusion), and be ostracised (United Nations General Assembly, 2017).

The trainee recognises caregiving may be more acceptable in certain relationship types in certain cultures, therefore findings may vary between interpersonal relationships as well as cultures. Dilworth-Anderson's 20-year narrative review (2002) highlights that White caregivers were likely to care for a spouse, whereas African American caregivers often cared for siblings, friends or extended family members. Research suggests gender differences exist, with more females taking on the caregiving role (Caqueo-Urízar et al., 2014). However, in some cultures, women provide personal care and emotional support, whilst men provide equal caregiving but focussing on financial support and transportation (Delgado and Tennstedt, 1997). In some cultures, sociological explanations emphasise the societal and cultural expectations of women to adopt the role of a caregiver. For example, Confucianism places value on women in some cultures assuming caregiver roles, regardless of other responsibilities such as having their own families to care for (Hsiao et al., 2006).

Siblings of People with Experiences of Psychosis (SOPEP)

The experiences of people with psychosis may impact the whole family through experiences of emotional and economic stress and caregiver burden (Wang et al., 2017), however research and treatment typically involves spouses and parents (Onwumere et al., 2020). The sibling relationship often provides reciprocal friendship, emotional and practical support (Bank & Kahn, 2003). Some SOPEP may have more knowledge of their sibling's difficulties than their parents (Dyregrov & Dyregrov, 2005) and take on caregiving support (BPS, 2021). In some cultures, SOPEP may be obligated to provide care for an "ill" sibling and socialised to the caretaking role, as well as act as sources of support to their parents (Amaresha et al., 2014; Bowman et al., 2017). Quantitative research and the literature exploring the experiences of SOPEP and their relationship is limited (Bowman et al., 2014; Plessis et al., 2020). Psychosis related symptoms and behaviours observed by SOPEP has been associated with psychological distress for SOPEP and conflict in family relationships (Lively et al., 2004; Plessis et al., 2020). A history of exhibiting physical violence, aggression and suicidal behaviours in individuals with FEP resulted in higher caregiver burden and lower quality of life for siblings (Bowman et al., 2014; 2017). Siblings may make sacrifices within their personal lifestyle (e.g., time with their spouse and children) to facilitate providing long-term care (Bowman et al., 2017). SOPEP providing care may encounter a wide range of complex,

layered emotions, experiences of stigma, increased distress, and burden (Bowman et al., 2014; 2017). However, they may experience positive emotions from providing support and companionship (Bowman et al., 2017).

Several theories conceptualise the impact of mental distress on siblings. Family systems theory asserts that family members are part of a symbiotic, dynamic family system, whereby the behaviour of each member has the capability to impact others (Minuchin, 1988). This is particularly relevant, as a diagnosis of psychosis is often in late adolescence and early adulthood. Disruption to relationships for siblings during this stage of life may have significant implications, specifically to personality development, identity formation and social support (Bowman et al., 2014). For example, a lack of attention and affection perceived by siblings may result in greater empathy or withdrawal behaviours (Fleary & Heffer, 2012). SOPEP who experience difficulties in psychosocial functioning may be at high-risk of developing psychosis themselves (Yung et al., 2005) and vulnerable to developing mental health problems (Bowman et al., 2014).

To understand the psychosocial needs of SOPEP and guide further practice and research, a systematic descriptive review was conducted (Amaresha et al., 2014). The review included seven studies (four qualitative; two quantitative and one mixed method study) and found SOPEP have specific needs. The authors highlight SOPEP's desire for support from professionals for both their own psychosocial needs and information and/or understanding of their sibling's difficulties, illness management and rehabilitation. A more up-to-date review incorporating studies across diverse cultures and across the psychosis umbrella (i.e., including ARMS, FEP) would help to inform services how best to support SOPEP's stressors and psychosocial needs across cultures.

Current Study

This study focusses on qualitative studies, due to the richness and number of qualitative research papers across cultures that are identified in a relatively novel area. This narrative systematic review enabled a consolidation of descriptive themes to determine the extent to which services provide support to siblings and guide further practice and quality research with this population. With this background, we systematically reviewed studies which explored the psychosocial stressors of SOPEP. Psychosocial stressors were defined as

perceived personal and social resources, including appraisals of care demands, coping styles and social support (Ownsworth & Karlsson, 2022).

Aims

1. Identify studies focusing on the psychosocial stressors of SOPEP as derived from qualitative studies.
2. Provide a narrative synthesis of the psychosocial stressors of SOPEP to date and assess the quality of the literature.
3. Explore culturally specific psychosocial family and sibling-centred support.

2. Methods

2.1. Search Strategy

This review was conducted in line with PRISMA guidelines for reporting systematic reviews (Moher et al., 2009; Page et al., 2021). The published review protocol can be found on PROSPERO https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=297598.

An electronic advanced search was carried out on six databases PsycINFO, EMBASE, CINAHAL, MEDLINE, PubMed and Web of Science using the search terms below. These searches were limited from October 2013– February 2023, involving human subjects, and written in the English language. The references in each included paper were reviewed through forwards and backwards searching, for extra relevant publications not identified in the initial electronic search.

The authors used the following search terms to be open and inclusive to any qualitative research involving a population of siblings of someone with experiences of psychosis. The authors were aware that this may result in a greater number of initial articles that required full text searches, however, felt that this was important due to the breadth of the area. The search terms were: psychosis OR psychot* OR schizo* OR early intervention in psychosis OR FEP OR first-episode psychosis OR first episode psychosis OR first episode of psychosis OR severe mental illness OR severe mental disorder AND Sibling* OR brother* OR sister* AND qualitative OR ethnograph* OR phenomen* OR grounded theory OR qualitative valid* OR purposive sampl* OR observational method* OR content analys* OR thematic analys* OR constant comparative OR field stud* OR theoretical sampl* OR discourse analys* OR focus group* OR lived experience* OR life experience* OR narrative analysis OR interview*.

2.2. Inclusion Criteria

Eligible studies were original research papers, published from October 2013, in peer-reviewed journals in English. Qualitative empirical research studies and mixed-methodological studies that included a qualitative element were included. Studies involving people with *"severe mental illness"* required 50% of the sample to have a psychosis cluster diagnosis. Eligible studies focused on stressors of SOPEP, which could be from the perspectives of either the sibling, another family member, healthcare professionals, or the patient. Siblings of all ages and those cohabiting or not cohabiting with their sibling were eligible for inclusion.

2.3 Exclusion Criteria

Studies exploring genetics and pathophysiological risk were beyond the scope of the review. All other study designs were excluded (e.g., quantitative studies, grey literature).

2.4.Study Selection and data extraction

The article selection process is illustrated in Figure 1. The initial search retrieved 2,438 citations. Duplicate results were removed using Endnote before titles and abstracts were screened for inclusion. Full text articles were obtained for all potentially eligible studies, which were then reviewed according to eligibility criteria. The trainee (EI) assessed study eligibility with queries resolved through discussion and consensus with additional review team member (MK). A second rater (JR) assessed reliability of the selection process by reviewing 30% of abstracts and 25% full-text papers. Estimates of inter-rater reliability showed high-level of agreement at screening ($\kappa=0.84$, $p<0.001$) and full-text stages ($\kappa=1.00$, $p<0.001$; Landis & Koch, 1977). EI screened 41 full texts of the remaining articles; 19 were excluded due to: The publication year prior to October 2013 ($n=3$), the study design ($n=8$), not focussing on a population of people with psychosis cluster diagnoses ($n=5$) or the focus not looking at the psychosocial needs of siblings ($n=3$).

The trainee contacted authors from the papers identified to gain additional information. Three additional papers were identified from reviewing citations. Twenty-two papers met full inclusion criteria and a data extraction tool was developed (see Table 1) to record: (1) Study characteristics; (2) Design; (3) Sample demographics for study participants; (4) Sample demographics for SOPEP; (5) Sample demographics for patients; (6) Study aims, key

findings and implications. Of the extracted papers, 30% were reviewed by both the trainee and a second rater to assess inter-rater reliability, with 90% agreement, and any discrepancies resolved through discussion.

2.5.Quality Assessment Tool

Assessment of methodological quality was conducted by the trainee using the Critical Appraisal Skills Programme (CASP; CASP International Network, 2013) qualitative checklist. This tool consists of ten questions that can be used to critically assess quality across qualitative methodologies. There is a general lack of consensus regarding assessing quality in qualitative research (Leung, 2015). Given the diverse forms of qualitative research from diverse cultures and countries, the trainee did not exclude studies based on quality. Of the included papers, 30% were reviewed by both the trainee and a second rater to assess inter-rater reliability, with 97.1% agreement reached across all domain ratings (see Table 2).

2.6. Narrative Synthesis

The data was summarised and analysed using narrative synthesis to "tell the story" of the findings from the included studies (Popay et al., 2006). The narrative synthesis approach involved developing a preliminary synthesis and exploring relationships within and between studies to draw out conclusions (Popay et al., 2006). The themes and extracts from included papers were re-read several times by the first author. During the full-text screening and extraction processes, we identified multiple studies that commented and reported on key areas. Using an inductive, iterative process, initial codes were created and then condensed and categorised until patterns and final themes emerged. This approach was used to combine and report the findings relating to the psychosocial stressors, needs, barriers and facilitators of caregiving for SOPEP. The identification of codes, and subsequently, the development of final themes, was discussed and reviewed in supervision. Relevant quotes were chosen to reflect key points within each theme.

2.7. Reflexivity

When conducting qualitative research, reflexivity is important in understanding the influence of researchers' backgrounds and perspectives (Malterud, 2001). The trainee's own experiences of family life, a positive sibling relationship and prior research with families of ARMS individuals, may have influenced her reasons for engaging and understanding siblings' experiences. For example, coming from a White British religious lens may have

influenced the trainee's perspective of carer burden, cultural and gender norms. Supervision was important to maintain an objective research position and ensure that themes were grounded within the data.

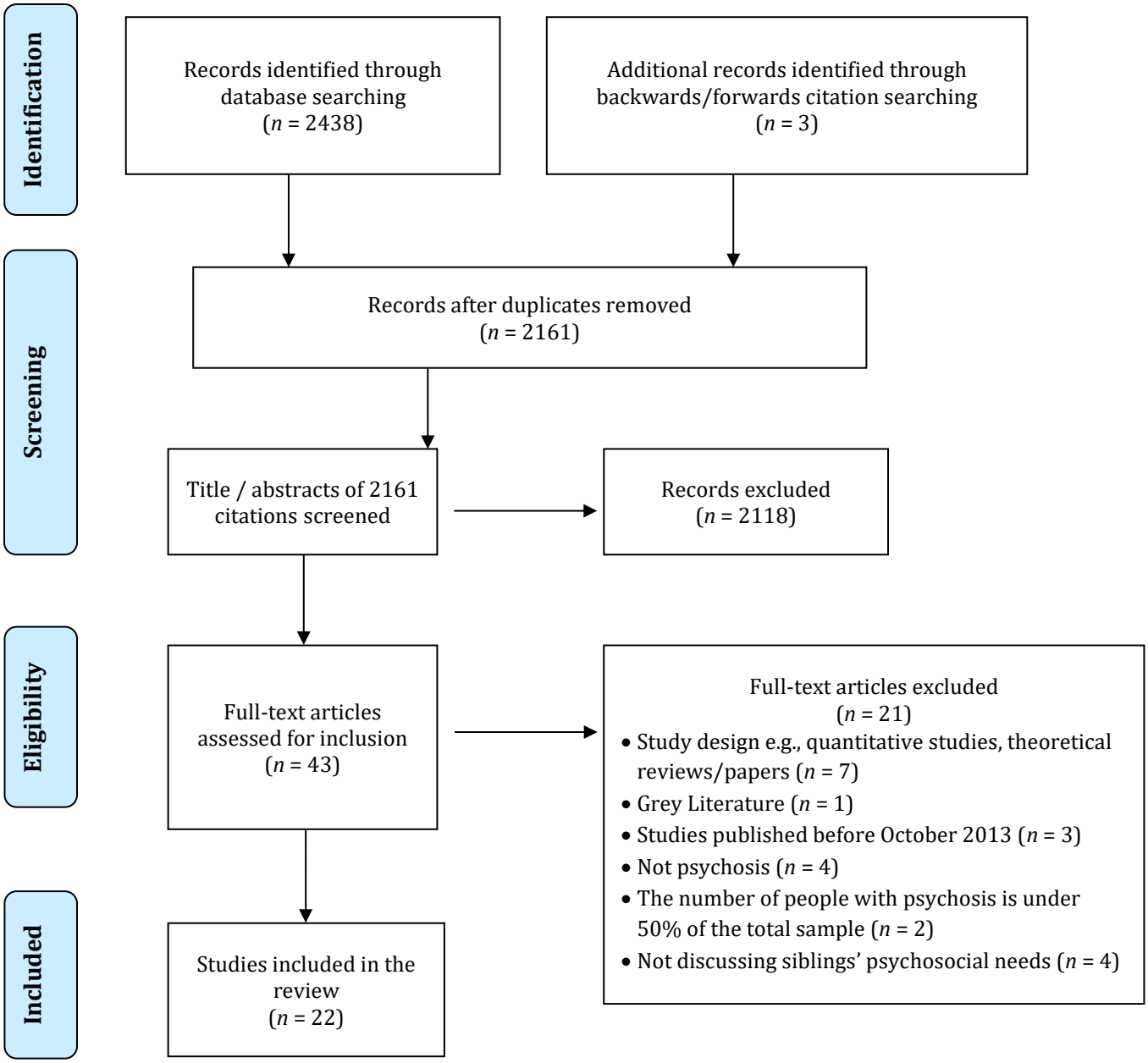


Figure 1. PRISMA flow diagram of systematic search

3. Results

3.1 Overview

The studies included were conducted within Europe (*n*=3), Asia (*n*=9), the Americas (*n*=5), Africa (*n*=2) and the Middle East (*n*=3). They explored the psychosocial stressors of SOPEP

with an ARMS (*n*=1), FEP (*n*=3) and diagnosis of schizophrenia or psychotic disorder (*n*=18). Of the 18 studies involving patients with a diagnosis of schizophrenia, seven studies involved inpatient populations (Al-Sawafi et al.,2021; 2022; Day & Petalas, 2020; Liu & Zhang, 2020; Park & Lee, 2017; Seeman, 2017; Yang et al., 2017). Study participants were only siblings (*n*=10), relatives (i.e., parents, partners, siblings, grandparents; *n*=7), patients themselves (*n*=1) and healthcare professionals (*n*=2). One study included both patients and relatives in their sample (Paul & Nadkarni, 2017), and another included both relatives and healthcare professionals (Al-Sawafi et al., 2022).

Most studies involved individual interviews (*n*=18). One study involved interviews and observations (Napa et al., 2017), one interviews and focus groups (Paul & Nadkarni, 2017), one open-ended questions on a questionnaire (Bishop & Greeff, 2015), and another involved observation of clinical notes (Seeman, 2013). Qualitative data analysis included grounded theory (*n*=6), thematic analysis (*n*=3), IPA (*n*=3), framework analysis (*n*=2), content analysis (*n*=3), descriptive phenomenological investigations (*n*=3) and general inductive approach (*n*=2).

Of the 22 studies, most siblings involved were female (*n*=10). Six studies did not mention the genders of the siblings, and two studies had an even split of male/female participants. Siblings were typically aged 25-39 years (*n*=11). One study looked at young siblings (Liegghio, 2017), and one explored siblings who ranged from 30-65 years (Yang et al., 2017). Seven studies did not mention ages of siblings. Additional details were sometimes mentioned about siblings, e.g., whether they lived with the patient (Amaresha et al., 2015; 2017; Dodge & Smith, 2019; Udgiri et al., 2017), were the primary caregiver (Amaresha et al., 2015; 2017), and the birth order (Dodge & Smith, 2019; Kovacs et al., 2019; Liegghio, 2017). See Table 1 for summary details.

In addition, three groups reused their data to publish multiple papers (Al-Sawafi et al., 2021; 2022; Amaresha et al., 2015; 2019; Graves et al., 2020; 2021). The weight of these papers has been taken into consideration in the result and discussion.

Table 1. Summary of included studies

No.	Study Characteristics (Authors, year of publication, country where the research was performed)	Study Aim	Design (Qualitative design)	Data Analysis	Sample Group Characteristics			Key Findings	Clinical Implications
					Study Participants (Population/relationship, sample size (*n*), gender composition, mean age)	Siblings (Sample size (*n*), gender composition, mean age)	Patients (Stage of psychosis; gender composition, mean age)		
1	Al-Sawafi et al., 2021 Oman	Explore the experience and needs of Omani relatives of hospitalised patients diagnosed with SZ.	Descriptive qualitative design. In person, semi-structured interviews in Arabic with family members of hospitalised patients with SZ. Purposely sampling of parents, spouses, and siblings.	Framework analysis (Ritchie & Lewis, 2014)	Relatives *n*=20 (Parents *n*=10; Siblings *n*=5; Partners *n*=5) Females – *n*=12 (60%) Age range 25-60 years	*Siblings* *n*=5 (25%) Female *n*=4 Age range 25-39 years	Inpatients with diagnosis of SZ *n*=20 No other details reported	1. Caregiving can impact emotions, finances, work etc. 2. SOPS experienced sadness, worry, feeling powerless, frustration, stigma, guilt, shame, and responsibility. Siblings tried to ignore negative comments. 3. SOPS experienced compassion and love, which enhanced close sibling-bonds and personal development. 4. Siblings encouraged patient's involvement in activities to support their independence.	Culturally adapted FI to effectively assist relatives in providing care and adjusting to the caregiving role are needed to reduce burden and stigma.
2	Al-Sawafi et al., 2022 Oman	Explore relatives' and mental health professionals' views to inform development of FI for inpatient with SZ diagnosis.	Semi-structured interviews with caregivers (see above). Three focus groups with staff members in English.	Framework analysis (Ritchie & Lewis, 2014).	Caregivers *n*=20 *(see above study for details)* Staff focus groups: Psychiatrists (*n*=7) Psychiatric nurse (*n*=5) Both professions (*n*=6)	*See above study for details*		Psychosocial needs include: 1. Knowledge: prognosis, symptoms, aetiology, treatment etc. 2. Problem-solving skills, e.g., managing when symptoms conflicted cultural practices. 3. Emotional support.	Culturally adapted FI would be acceptable to caregivers, when tailored to the families' needs.

					Experience range 4-32 years				
3	Amaresha et al., 2015 India	Explore the needs of the SOPS, who attend a tertiary care mental health hospital in Southern India.	Qualitative exploratory study using semi-structured in-person interviews in Kannada, Tamil, Telugu, or English. Purposive sampling.	General Inductive Approach (Thomas, 2006).	Siblings *n*=15 Male *n*=11 Mean age = 33 years Identified as primary caregiver *n*=10 Living with the patients *n*=9 Urban background *n*=9		Diagnosis of SZ *n*=15 (paranoid SZ *n*=9) Mean age = 30.40 years	1. Siblings wanted help managing the negative symptoms, access to information, and discuss concerns e.g., hereditary. 2. Negative impacts on socio-occupational functioning, unemployment, and family burden.	Specific psychosocial Interventions in India are needed to support SOPS understanding and facilitates caregiving.
4	Amaresha et al., 2019 India	Explore SOPS' experiences, attitudes, and perspectives from the onset of illness.	*See above study for details*					1. SOPS expressed negative attitudes towards their sibling when they believed they could control the illness. 2. SOPS experienced subjective and objective burden. 3. SOPS proactively engaged in their sibling's care, e.g., treatment adherence, support their livelihood. 4. SOPS used adaptive and maladaptive strategies, e.g., distraction, internalising feelings.	Information and open discussions around avoidance, burden, grief, stigma, and isolation would benefit SOPS. Families may attribute that the symptoms can be controlled by the patient, which clinicians must address in interventions.
5	Bishop & Greeff, 2015 South Africa	Identify resilience qualities in families of individuals diagnosed with SZ.	Cross-sectional mixed-method research design. Qualitative open-ended question on a questionnaire.	Thematic analysis (Braun & Clarke, 2006).	42 families, represented by 33 parents (27 mothers) and 9 siblings of the diagnosed family member.	Siblings *n*=9 (21%) All aged 18 years +	Diagnosis of SZ *n*=42 Males *n*=33 (79% sample) Mean age = 31 years	1. Resources that helped families adapt were social support, characteristics within the family (e.g., family time) and communication and attitudes towards the patient.	Siblings may benefit from specific support and interventions that focus on their needs and resilience.

							2. Siblings engaged in the caregiving and involved them in social activities.	
6	Day & Petalas, 2020 UK	Address the perceptions of sibling relationships from the perspective of patients with mental health difficulties.	Qualitative semi-structured interviews.	IPA (Smith et al., 1999; Tindall, 2009)	Primary diagnosis of a psychotic disorder *n*=9; PTSD and EUPD *n*=1 Male *n*=10 Ages range 18- 55 years Inpatients at a Rehabilitation Hospital *n*=10 Sibling included biological, adopted and stepsiblings, ranging from 1-8 number of siblings (mean *n*=3.4)		1. Patients felt guilty being cared for by their siblings and noticed change in sibling dynamics, particularly following diagnosis, and hospitalisations. 2. Siblings provide an alternative support to parents and support patient's mental health and recovery. They were often protective factors and be positive/negative influences.	Services should offer private spaces within and outside hospital settings to allow siblings to meet and interact. Involving siblings could help patient's wellbeing, QOL and be resources of historical data and helpful for future planning.
7	Dodge & Smith, 2019 Canada	Examine transitions, constraints, and experiences as a caregiver following their sibling's diagnosis.	Qualitative semi-structured interviews in person. Purposive sampling.	Grounded theory (Charmaz, 2006).	Siblings *n*=10 Male *n*=5 Age range 21-56 years (mean = 32.2 years) Sibling number range 1-4 Older sibling of patient *n*=4 Living with patient *n*=1	Diagnosis of SZ *n*=10 Male *n*=8 Age range 26-46 years (mean = 32.5 years)	1. Siblings play a key role in supporting their ill sibling in the community. 2. Initially struggled with sibling's dependency but over time appreciated small successes. 3. Siblings were ambivalent towards responsibilities as future primary carers.	Siblings need to be integrated in care decisions and supported with problem-solving skills and techniques, which will help them long-term.
8	Graves et al., 2020 USA	How siblings of individuals with SZ experience family crises and the influences on	Exploratory qualitative study, 1-1 interviews conducted via Skype, with one interview conducted in person. Purposive and snowball sampling.	Grounded theory techniques (Charmaz, 2014; Saldaña, 2015)	Siblings *n*=23 Male *n*=10 Aged between 18 - 30 years Caucasian *n*=21; Latino *n*=1; Native American ancestry *n*=1	Diagnosis schizoaffective disorder or SZ *n*=23 (two had died before the interview) Male *n*=19	1. Parents varied in how they responded to sibling's emotional needs i.e., support, attention, involvement. 2. Parents more attuned to the emotional needs of siblings reduced their anxiety and were deemed more mastered at	Fostering a cohesive family unit or FI should include siblings e.g., family communication, crisis managing and discussions of siblings

		their own development.					Age range 20-37 years Caucasian *n*=21; Latino *n*=1; Native American ancestry *n*=1	managing challenges within the family.	as potential future caregivers.
9	Graves et al., 2021 USA	Examine how emerging adult siblings experience their developing awareness of their siblings' SZ.	*See above study for details*					1. Open communication between parents and sibling positively influenced their perception of family unity and family relationships. 2. The sibling's own emotional availability and sense of self was important in how they viewed their role in the family.	Increased mental health support would benefit siblings, who experience developmental, identity changes as well as family crisis/conflict.
10	Izon et al., 2021 UK	Understand siblings of individuals with an ARMS.	Qualitative semi-structured interviews using a critical realist approach. Convenience sampling.	Thematic Analysis	Caregivers *n*=14 Mothers *n*=9; partners *n*=4; sibling *n*= 1. All the mothers (aged 41–56 years) lived with the patient: five had additional younger children living in the family home, one lived alone with the patient, and three had older children who no longer lived with the family.	One sibling - aged 31 years, Female White British	At Risk of Psychosis aged 17-34 years (mean age 21.15), Male *n*=9.	1. Mothers' behaviour impacted on other siblings, e.g., less attention, time together. 2. Disruptions and stress for siblings at home included involvement of social services. 3. Siblings lack information or understanding of the patient's difficulties. They may show similar emotional reactions to their parents, which can impact the sibling bond.	Siblings may benefit from support in managing the changes in the family, e.g., relationships and involvement in FI could create family cohesion e.g., open communication, how they feel about situations and spending time listening to one another.

11	Kovacs et al., 2019 Israel	Understand the adult sibling bond, when one experiences mental health problems and the other may not be the primary caregiver.	Qualitative semi-structured in person interviews in Hebrew. Purposive sampling.	IPA (Smith et al., 2009)	Siblings *n*=14 Age 20-55 years Male *n*=7 Ethnicity: Israeli *n*=13; Arab Israeli *n*=1 Oldest sibling *n*=5		Diagnosis: SZ *n*=9; Bipolar *n*=2; eating disorder *n*=4; OCD *n*=1 Male *n*=8 Aged 25-49 years	1. Siblings spoke about dilemmas e.g., wanting to be close/involved but desiring distance. They found balancing involvement tough. 2. Communication between siblings could be confrontational, demanding, closed. 3. Siblings who took on parental burden spoke about a lost sibling friendship/boundary ambiguity.	Services should encourage the involvement of siblings in FI and provide psycho-education groups and dyadic sibling therapy to help siblings and provide opportunities to process internal and interpersonal relationship challenges.
12	Liegghio, 2017 Canada	How young siblings experience their sibling's mental health and the impact on their family and sense of self.	Semi-structured interview. Purposive sampling.	Thematic content analysis based on grounded theory using an inductive process (Strauss & Corbin, 1998).	Siblings *n*=7 Male *n*=3 Age range 13-21 years Younger sibling *n*=4		Diagnosis: FEP *n*=4; ADHD *n*=1; Bipolar *n*=1; Depression *n*=1 Male *n*=6 Age range 12-22 (mean = 16 years)	1. Siblings describe negative experiences of worry, stress, burden, and family conflict. They hesitate from talking openly to avoid stigmatising encounters and protect their sibling. 2. Some behaviours were seen as patient's character e.g., purposeful or attention-seeking. 3. They felt parental openness and peer support would be helpful.	Young siblings may benefit from opportunities to talk about the illness through sibling-sibling peer support. This may also help reduce isolation, stigma and normalise their experiences.
13	Liu & Zhang, 2020 China	Explore the experiences of caregivers of people with SZ.	Descriptive phenomenological approach using semi-structured 1-1 interviews in Putonghua. Purposive sampling.	Inductive content analysis (Elo & Kyngas, 2007; Morse et al., 2002).	Caregivers *n*=16 (parents *n*=11; spouses *n*=3; sibling *n*=1; child *n*=1) Age range 25-58 years (mean = 44.75 years)	One sister	Diagnosis of SZ *n*=16 Male *n*=9 Mean age = 27 years Inpatient *n*=16	1. Caring can disrupt the family relationships. 2. Siblings felt unconditional love and sense of responsibility for supporting the patient and their family.	The involvement of all family members in FI –culturally valued in China. Also, clinicians may benefit from further training.

14	Napa et al., 2017 Thailand	Explore the family interactions and behaviours of Thai families.	Semi-structured, in-depth interviews and observations of family's communication and behaviours towards each other and the patient. Purposive and theoretical sampling.	Grounded theory methodologies (Strauss & Corbin, 1998).	31 participants from 18 families including parents, siblings, aunts, grandparents Age range 25-46 (*n*=16) and >45 (*n*=15) Rural *n*=16	One sibling from one family.	Diagnosis FEP *n*=18 Aged 18-25 years	1. Siblings' shared caregiving responsibilities with family members e.g., companionship and essential care (i.e., washing clothes). 2. Siblings' rules for growing up were sometimes different from patients, on account of their mental health.	Extended family and key persons in the community (e.g., shamans, monks, neighbours) should be considered as a support resource. Plus, better sharing of information to rural areas.
15	Park & Lee, 2017 Korea	Korean sibling caregivers' experiences caring for a sibling diagnosed with SZ.	Qualitative in-depth semi-structured face-to-face interviews in Korean. Purposive and snowball sampling.	Descriptive phenomenological investigation (Colaizzi, 1973; 1978).	Siblings *n*=8 Female *n*=5 Age range 20-40, the majority in their 20's (*n*=4)		Diagnosis SZ *n*=8 Inpatient *n*=8	1. Siblings experienced a mix of emotions: positive (love, positive regard) and negative (frustration, fear, helpless, burden). 2. Siblings had lack of understanding but were committed to learning about the illness. 3. Siblings felt responsible and obligated to caring for the patient.	Programs for siblings (e.g., normalising complex emotions, education) would aid siblings and consequently improve the wellbeing of patients.
16	Paul & Nadkarni, 2017 India	Understand patients' and families' illness-related experiences, with specific attention to acceptance, stigma, and discrimination.	In-depth interviews with people with SZ and five focused group discussions with their caregivers, in Hindi or English. Purposive sampling.	Ground theory (Rose et al., 2002)	Caregivers *n*=14 (parents *n*=8; spouse *n*=3; sibling *n* =1) Male *n*=7	One brother who started caregiving after 15 years of the onset of his brother's illness.	Diagnosis SZ or related disorder *n*= 20 Male *n*=10 Age range 27-59	1. Siblings perceived negative impacts of caring (e.g., marriage prospect, career development) and increased burden. 2. Siblings who were more established in their profession and married were more receptive to caregiving roles. 3. Siblings who perceived stigma from society were more likely to avoid their ill sibling.	Educating families about SZ (i.e., knowledge and practical skills) to enhance family cohesion and acceptance. Support groups would help challenge family attitudes. Wider education would help reduce societal stigma and discrimination.

17	Purba, 2017 Indonesia	Explore caregivers needs when caring for someone with SZ.	In depth interviews - phenomenology design.	Colaizzi's method of analysis (Polit & Beck, 2008).	Family members *n*=8	Unknown details	Diagnosis SZ *n*=10	1. Siblings have similar challenges to other caregivers and developed ways to cope and reduce family tension. 2. Psychosocial needs included information about SZ (treatment, causes, symptoms, effects of medication) and peer support.	Nurses could be a helpful resource to support families (i.e., knowledge and practical skills).
18	Seeman, 2013 Canada	Identify gaps in knowledge about siblings and caregiving of people with SZ	Observation and documentation of clinical notes (recorded once a week on average over ten years).	Over 12,000 written observations of 25 women, 200 related to the sibling relationships .	Diagnosis SZ *n*=25 Female *n*=25 Age range adolescent-elderly Details about siblings are unknown (to maintain confidentiality/anonymity)			1. Siblings are important in the social network. When parents cannot cope, siblings are more active. 2. The eldest female often assumed primary caregiver role (dependent on culture, family values, personal circumstances). 3. The caregiving role was often stressful, with burden eased when responsibility was shared between family members.	Include siblings in FI sessions, and provide psychoeducation (e.g., how to balance the responsibility and burden of caregiving). Siblings' details should be on record.
19	Sin et al., 2017 UK	Explore the challenges of recruiting siblings of people with FEP into a RCT.	Qualitative semi-structured interviews with clinical and research staff involved in recruiting siblings into an RCT.	Thematic analysis (Ritchie et al., 2003).	Staff from early intervention to psychosis services *n*=12 (principal investigators *n*=4; clinical studies officer or clinical studies assistant *n*=4; clinicians *n*=4).	No sibling involvement.	Diagnosis of FEP	1. Parents may shield children or prioritise the patient, resulting in siblings having less parental attention. 2. Siblings who have no or minimal contact with services may have limited access to support (e.g., advocating for their own needs)	A routine comprehensive family assessment in clinical settings e.g., genogram, family network map.
20	Udgiri et al., 2017 India	Identify the needs of	Exploratory qualitative approach and semi-structured face to-face	General inductive approach.	Family members *n*=11 (included	*N*=3 (27.3% sample).	PwFEP diagnosed	1. Siblings left their job to take a caregiver role. Psychosocial needs include:	Needs based interventions in meeting the

		Caregivers of PwFEP	interviews in either Kannada, Telugu, Hindi, or English.	(Thomas, 2006).	mothers, fathers, children, siblings) Mean age 36.18 years	All living with the patient.	with paranoid SZ (*n*=5) Mean age 32.50 years	2. Information and knowledge (e.g., aetiology, symptoms, medication). 3. Social welfare, legal and financial support. 4. Emotional support (e.g., their own mental health, managing stigma).	psychosocial needs of caregivers of PwFEP in India.
21	Yang et al., 2017 China	Understand siblings' experiences as the primary caregiver of patients with SZ in Taiwan.	Semi structured, in-depth interviews.	Qualitative content analysis (Graneheim & Lundman, 2004).	Siblings *n*=10 Male *n*=3 Mean age = 44.9 years (range 30–65)		Diagnosis SZ *n*=10 Inpatient *n*=10	1. Caregiving started when parents were unable to manage tasks. 2. Demands on siblings (e.g., financial, work) depended on if they lived together and closeness. 3. Emotional support needs (e.g., concerns about the future, feeling helpless).	Psychoeducation and FI should support siblings cope and promote family cohesion.
22	Young & Flannigan., 2021 South Africa	Understand "*Black*" isiXhosa-speaking persons experiences as siblings of someone with a SMI.	Semi structured, interviews in siXhosa. Purposive and snowball sampling.	IPA (Willig, 2013).	Siblings *n*=5 (including uncles *n*=2) Male *n*=1 Aged 22-49, mean = 29.4 years. Black Christian *n*=5		Diagnosis SZ *n*=4, bipolar mood disorder *n*=1.	1. Families used traditional healers and western public healthcare facilities concurrently or sequentially. 2. Caregiving was positive (e.g., closer sibling bond, better understanding of mental health). 3. Caregiving was a burden (i.e., responsibility, self-sacrifice, financial, stigma, shame, fear).	More integration and dialogue between traditional healing belief systems and western healthcare. Siblings can also be a valuable resource for challenging social stigma.

Abbreviations. No. = number; PwFEP = persons with first episode psychosis; SZ = schizophrenia; FI = family intervention; IPA = interpretative phenomenological analysis; SMI = severe mental illness; SOPS = siblings of people with schizophrenia; ARMS = at risk mental state of psychosis; RCT = randomised control trial; PTSD = Post-Traumatic Stress Disorder; EUPD = Emotionally Unstable Personality Disorder; QoL = quality of life; MH = mental health; FEP = first episode psychosis.

Note. Some of the papers included the same sample across two papers, which has been taken into consideration during the discussion. For the purpose of the review, the term "patient" is used for persons experiencing symptoms of psychosis. Those providing care and support are referred to as "caregivers" and "carers." It is worth noting that papers varied in their definition of "sibling". The socially constructed nature of siblings is not unusual in Black South African families, particularly in rural areas, where social and household relationships are fluid; therefore, this study included step-, half-, biological, and socially constructed siblings.

The 22 papers are presented in chronological order. The table is a summary of the studies, containing key findings and implications, and demographic characteristics about the sample participants, the sibling, and the patient. Some of these details were not reported. The trainee (EI) contacted the corresponding authors to gain further information.

3.2 Quality Assessment Tool

The received studies provided clear aims, were explicit about how data was collected and chose appropriate qualitative methodology. However, some were not rigorous with data analysis (see Table 2, criteria 8) and did not critically consider the researcher's own role, influence, and potential bias (see Table 2, criteria 6). All studies were included as deemed valuable research to existing literature, with findings important to consider in current practice and policy.

Table 2 illustrates the similar scores of the papers quality assessed by two separate raters. The 10 questions were answered "*yes*" or "*no*" or "*can't tell*"; the criteria and prompts for each question can be found in Critical Appraisal Skills Programme (CASP) International Network (2013). Overall, the papers included in the review provided valid study results that provide implications for research and practice. Some papers did not provide information about the methodology or results or were unclear with regard to how researcher reflexivity was reported.

Table 2. Quality review of the 22 included studies in chronological order

Source	Rater	Criteria									
		Clear Aims	**Method**	**Design**	**Recruitment strategy**	**Data Collection**	**Researcher Bias**	**Ethical Issues**	**Data Analysis**	**Clear Findings**	**Research Value**
Al-Sawafi et al., 2021	A	1	1	1	1	1	3	1	1	1	1
	B	1	1	1	1	1	2	1	1	1	1
Al-Sawafi et al., 2022	A	1	1	1	1	1	3	1	1	1	1
Amaresha et al., 2015	A	1	1	1	1	1	3	1	1	1	1
Amaresha et al., 2019	A	1	1	1	1	1	3	1	1	1	1
Bishop & Greeff, 2015	A	1	1	1	1	1	3	1	1	1	1
	B	1	1	1	1	1	2	1	1	1	1
Day & Petalas, 2020	A	1	1	1	1	1	3	1	1	1	1
Dodge & Smith, 2019	A	1	1	1	1	1	2	1	1	1	1
Graves et al., 2020	A	1	1	1	1	1	2	1	1	1	1
Graves et al., 2021	A	1	1	1	1	1	2	1	1	1	1
Izon et al., 2021	A	1	1	1	1	1	1	1	1	1	1
	B	1	1	1	1	1	1	1	1	1	1
Kovacs et al., 2019	A	1	1	1	1	1	2	1	1	1	1
	B	1	1	1	1	1	2	1	1	1	1
Liegghio, 2017	A	1	1	1	1	1	2	1	1	1	1
	B	1	1	1	1	1	2	1	1	1	1
Liu & Zhang, 2020	A	1	1	1	1	1	1	1	1	1	1
Napa et al., 2017	A	1	1	1	1	1	2	1	1	1	1
Park & Lee, 2017	A	1	1	1	1	1	2	1	1	1	1
Paul & Nadkarni, 2017	A	1	1	1	1	1	2	1	1	1	1
	B	1	1	1	1	1	2	1	1	1	1
Purba, 2017	A	1	1	1	2	1	2	1	2	1	1
Seeman, 2013	A	1	1	1	1	1	2	1	2	1	1
Sin et al., 2017	A	1	1	1	1	1	1	1	3	1	1

Udgiri et al., 2017	A	1	1	1	1	1	2	1	1	1	1
Yang et al., 2017	A	1	1	1	1	1	2	1	1	1	1
Young & Flannigan., 2021	A	1	1	1	1	1	3	1	2	1	1
	B	1	1	1	1	1	3	1	2	1	1

Note. "1" = the publication provided an informative description of the criterion at issue and met the quality criterion; "2" = the publication provided an informative description, but an inadequate performance; "3" = the publication provided no or insufficient information; A, refers to rater number one (EI); B, refers to rater number two (JR).

3.3. Facilitators and barriers to providing care and supporting SOPEP

Using narrative synthesis, six key components were identified as contributing to SOPEP's psychosocial stressors and facilitating or hindering their intentions, behaviours, and experiences in providing care. These were (1) SOPEP's beliefs about psychosis, (2) caregiving beliefs, (3) family and cultural values, (4) personality traits, (5) pragmatic challenges, and (6) access to resources. Figure 2 was a key output of the synthesis, showing the psychosocial stressors that may **help (bold)** or *hinder (italic)* SOPEP intentions and behaviours in caregiving. The model includes influencing factors from an individual and social level, as well as physical and macro-level environments.

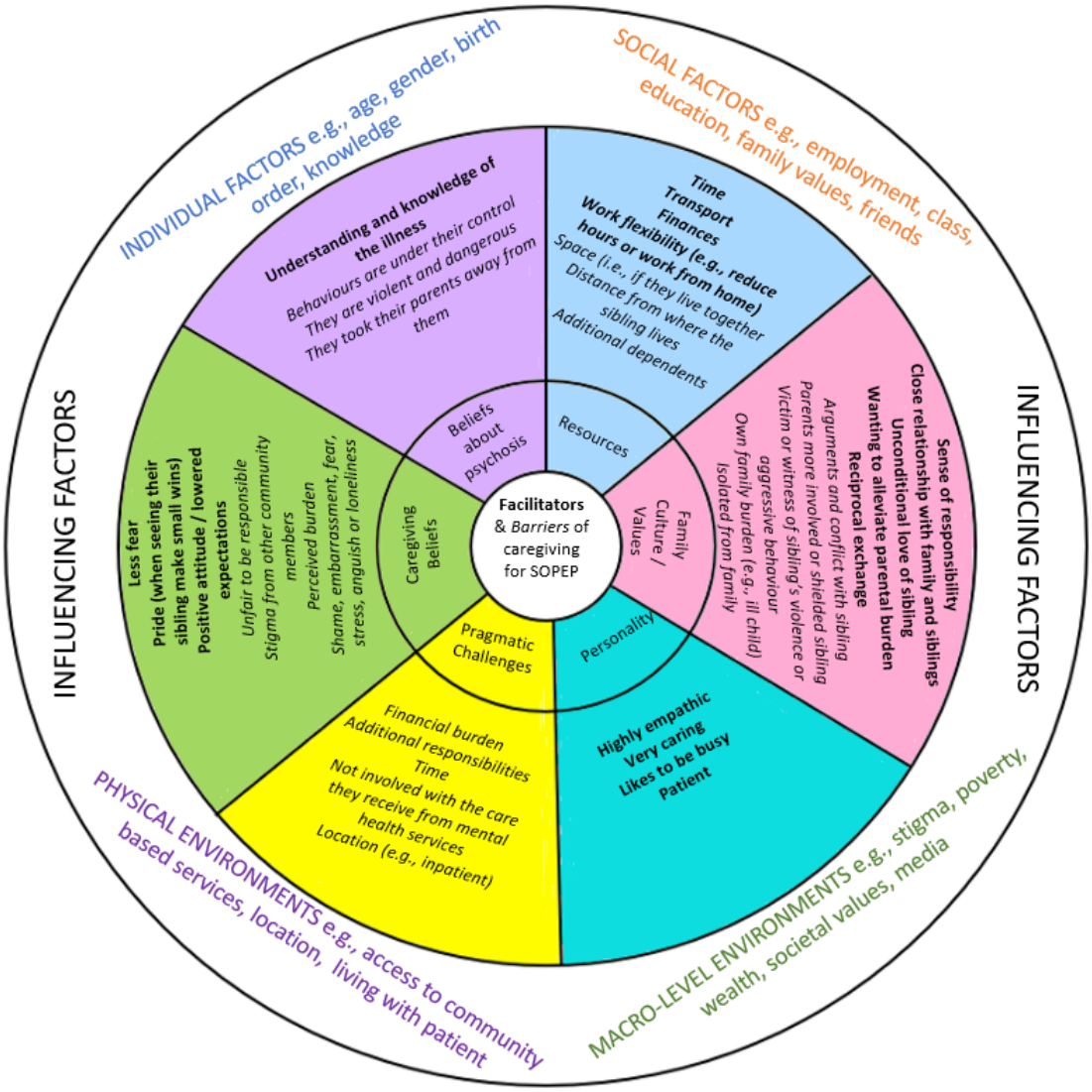


Figure 2. A key output of the synthesis, showing the facilitators and barriers to providing care and support for siblings of people with experiences of psychosis (SOPEP)

*The psychosocial stressors of siblings of people with experiences of psychosis (SOPEP) that may **help** or hinder their intentions and behaviours in providing care.*

3.3.1. Beliefs about psychosis

Social issues such as public stigma towards people with experiences of psychosis may result in negative stereotypes (e.g., aggressive, violent) (Napa et al., 2017; Liegghio, 2017) and discrimination (e.g., unable to own property) (Paul & Nadkarni, 2017; Liegghio, 2017). Negative perceptions of psychosis impacted on SOPEP feeling embarrassed, uncomfortable (Amaresha et al., 2015; 2019; Liegghio, 2017; Young & Flannigan., 2021; Al-Sawafi et al., 2022) and isolated from others (Graves et al., 2021; Liegghio, 2017; Amaresha et al., 2019).

"One of the neighbours suggested we move out of the neighbourhood… it was after (sibling) had an episode." (Liegghio, 2017)

Negative emotional experiences by SOPEP may be attributed towards their beliefs of their sibling's behaviours being intentional. These criticisms may elicit jealousy when combined with attention focussed on the patient and the SOPEP's needs perceived as less important (Seeman 2013; Izon et al., 2021).

"Yes, he has an illness… but that doesn't mean that he cannot do anything." (Amaresha et al., 2019)

"He is sometimes embarrassing you, us as a family. And then you feel those… and others were laughing. It was like he is doing it for fun." (Young & Flannigan., 2021)

Dependent on SOPEPs' personal and social identity, their experiences of having an "*ill*" sibling may vary. This may have an impact for SOPEP during adolescence and early adulthood on the sibling relationship (Graves et al., 2021), relationships with their parents (e.g., feeling abandoned) and their psychosocial functioning. SOPEP who experienced changes within family relationships (i.e., family conflict, involvement in caregiving, less attention/time with parents) may lack the knowledge and understanding of the condition (Amaresha et al., 2015; Al-Sawafi et al., 2022; Izon et al., 2021; Liegghio, 2017; Napa et al., 2017; Sin et al., 2017).

"We need to know some information such as what is the nature of the illness? Why does it occur? Why is my brother behaving like this?" (Amaresha et al., 2015)

3.3.2. Caregiving beliefs

SOPEP play a key role in caregiving with 17 studies mentioning siblings having a responsibility for the patient, and their families. SOPEP may be socialised to the caretaking role early in life (due to e.g., parental ill health, bereavement) and expected to care for their *"ill"* sibling. SOPEP may recognise themselves as adopting a *"parenting role"* (Graves et al., 2021; Izon et al., 2021), over their lifetime (Day et al., 2020; Graves et al., 2021; Kovacs et al., 2019; Yang et al., 2017). However, some may choose not to engage and avoid caregiving responsibilities and distance themselves from their sibling (Seeman, 2013).

"Up to what age are they our sibling? Our responsibility? Until when? Until age 40? Until age 50? Until age 60?" (Kovacs et al., 2019)

Studies highlighted the diverse forms of care SOPEP provided: Physical care included managing medication, appointments, providing transport and housing (Amaresha et al., 2019; Napa et al., 2017; Udgiri et al., 2017; Yang et al., 2017; Purba, 2017), emotional support included listening, providing advice and empathy (Al-Sawafi et al., 2021; 2022; Liu & Zhang, 2020), social support included providing companionship, social interactions, and access to activities (Al-Sawafi et al., 2021; Bishop & Greeff, 2015; Dodge & Smith, 2019; Napa et al., 2017; Seeman, 2013), and finally, financial support included transport, bills, disturbances in SOPEP's own occupation (Al-Sawafi et al., 2021; Amaresha et al., 2015; 2019; Udgiri et al., 2017; Yang et al., 2017; Young & Flannigan., 2021; Purba, 2017). Five studies did not mention specific psychosocial demands (Graves et al., 2020; 2021; Izon et al., 2021; Purba et al., 2017; Sin et al., 2017).

"She's, my sister! It is normal for family members to help each other when they are ill." (Liu & Zhang, 2020)

3.3.3. Family and cultural values

In some cultures, psychosis was described as *"bizarre"* (Graves et al., 2021) or "*picchi", "hucchu", "madness"* (Young & Flannigan., 2021; Amaresha et al., 2015; 2019) and the result of "*vamachara"* (black magic) or a *"Jinn'"* (Amaresha et al., 2015; 2019; Young & Flannigan., 2021; Al-Sawafi et al., 2021; 2022) or a message from G_d (Park & Lee, 2017). Help-seeking behaviours included accessing traditional healers prior to mental health services (Amaresha et al., 2015; 2019; Young & Flannigan., 2021; Al-Sawafi et al., 2021; 2022).

"We did not know where to go initially… some people told us to take him to temples and person poojas (religious rituals) and some advised seeking help from black magicians." (Amaresha et al., 2019)

Beliefs about caregiving and mental illness may be unique to culture (Amaresha et al., 2015; 2019). It is important to note that the majority of papers included in this review failed to report the researchers' own stances, which may be in line or conflicting with participants' family and cultural values. Variations in caregiving may be dependent on gender, geographic proximity, socioeconomics, other responsibilities of SOPEP (e.g., responsibilities for other children or aging relatives). In some cultures, families provide collectivist support to patients, and demands may be put on siblings rather than parents with expectations of their involvement in caregiving (Napa et al., 2017; Seeman, 2013).

"My elder brother and I work together. He said that its very important since I'm in Taiwan and cannot burn out caring for family members. My elder brother works in America and earns money to pay the bills for our ill brother, our parents, and their foreign caregiver." (Yang et al., 2017)

Some SOPEP may avoid caregiving because of the perceived burden and stigma (Day et al., 2020; Graves et al., 2021; Kovacs et al., 2019; Yang et al., 2017; Seeman, 2013) and/or family values (Graves et al., 2020; Kovacs et al., 2019). Stigma and discrimination may impede or delay help-seeking behaviours, further exacerbating symptoms and functioning (Amaresha et al., 2019) or result in families utilising institutions to avoid family burden (Yang et al., 2017; Park & Lee, 2017). SOPEP

may rely on their parents to sustain the caregiving role (Park & Lee, 2017; Dodge & Smith, 2019).

"When my parents die… I think (caregiving) would fall to me." (Dodge & Smith, 2019)

3.3.4. Personality traits

SOPEP expressed compassion, empathy and patience towards their sibling and wanting to be a calming presence when socialising together (Al-Sawafi et al., 2021; 2022; Liu & Zhang, 2020; Amaresha et al., 2019; Young & Flannigan., 2021; Bishop & Greeff, 2015; Day et al., 2020; Park & Lee, 2017; Graves et al., 2020). SOPEP desired patience when communicating with their siblings, mostly when they felt exhausted or frustrated by the sibling's behaviours (Kovacs et al., 2019; Amaresha et al., 2015).

"I like to just chill with him and take my guitar… his illness brought me close to him as his brother, I always want to be better!" (Young & Flannigan., 2021)

3.3.5. Pragmatic challenges

Most studies described the care demands for SOPEP. Some SOPEP described caregiving as stressful, burdensome, and associated negative impacts (Young & Flannigan, 2021; Seeman, 2013; Park & Lee, 2017; Liegghio, 2017; Kovacs et al., 2019; Amaresha et al., 2015; 2019; Paul & Nadkarni, 2017). SOPEP discuss the "*demands for money*" (Seeman, 2013) and financial burden from hospitalisation fees and medications (Amaresha et al., 2015; Park & Lee, 2017; Yang et al., 2017), whilst others had paid for traditional healers (Al Sawafi et al., 2021; Amaresha et al., 2019).

"I have no idea how to pay the hospitalisation fee." (Yang et al., 2017)

SOPEP in employment or education experienced pragmatic challenges in supporting their sibling to appointments and involvement in their care (Liegghio, 2017; Amaresha et al., 2019; Amaresha et al., 2015; Sin et al., 2015).

*"I also decided to leave the school. Oh man, sh*t! Everything is on me!... It's a burden." (Young & Flannigan., 2021)*

SOPEP may have additional responsibilities (i.e., families and young children) that create challenges in socialising and involvement in their sibling's care (Yang et al., 2017; Amaresha et al., 2015).

"These days I have a lot of pressures both personally and professionally…not able to spend time with my fiancé and friends." (Amaresha et al., 2015)

3.3.6. Access to resources

The need for additional resources for SOPEP was mentioned across all studies. Most studies discuss wanting emotional support within families or peer support around topics including avoidance, grief, stigma, burden and long-term caregiving responsibility. Over half of the studies discuss SOPEP's need for knowledge and psychoeducation about topics including symptoms, aetiology, social welfare, legal and financial support.

"I would like to know what psychosis is all about? What has caused this illness? How long will it take to cure?" (Udgiri et al., 2017)

Five studies (Al-Sawafi et al., 2022; Amaresha et al., 2015; Dodge & Smith, 2019; Graves et al., 2020; Paul & Nadkarni, 2017) discuss practical skills and techniques for SOPEP in managing symptoms. Four studies (Day & Petalas, 2020; Liu & Zhang, 2020; Seeman, 2013; Sin et al., 2017) discuss additional resources for healthcare professionals (e.g., culturally valued family intervention training, records of family networks).

Over half of the studies included in the review discuss culturally adapted interventions for SOPEP, due to unique concerns and beliefs about caregiving and possible conflicts with cultural practice. These studies discuss how programs may need to be adapted to account for the differences in language, stigma, and involvement of others (e.g., extended family, shamans, monks).

"It is important to use simplified language." (Al-Sawafi et al., 2022)

All the studies included in this review discuss strategies and programs needed to support SOPEP. Resources were grouped together as seen in Table 3. They were found to help siblings feel less stressed, isolated, and confused about the psychosocial demands as a SOPEP, and more positive and knowledgeable in how to support themselves and their sibling. These may need to be adapted to the SOPEP's needs depending on their personal and social identity, patient's stage of psychosis and cultural expectations and beliefs of caregiving.

Table 3. Resources to facilitate caregiving and cope with the psychosocial challenges as a sibling of someone who experiences psychosis

Psychosocial needs of siblings	**Examples of conversations and supportive resources**
Education to increase knowledge for siblings	• How to manage the illness and treatment (both positive and negative symptoms). • The aetiology of the illness. • What symptoms and signs to look for in the condition. • Discussions to help reduce stigma and burden (e.g., behaviours within the patient's control). • Hereditary factors. • Impact for sibling's long-term health and needs. • Empower siblings in managing mental health services.
Involvement in the patient's mental health care	• Involvement in the treatment plan and how they may support their sibling managing the illness. • Aware of which healthcare professionals are involved in the patient's care. • Involvement in family intervention.
Access to mental health support for siblings themselves	• Access to emotional support as a consumer in their own right. • Access to respite. • Encouraged to prioritise oneself (i.e., the idea in an aeroplane and put on one's own oxygen mask first). • Normalise mixed emotions. • Opportunity to discuss the future and caregiving when parents are unable to cope. • Opportunity to discuss distressing topics e.g., stigma, conflict, burden.
Access to social support	• Support from peers (e.g., family members and siblings of people with mental illness). • Involvement of extended family.

Access to financial advice	• Discussions about their employment and accessing support from work. • Signpost grants and financial support as a carer. • Supporting a sibling who is unemployed.
Encourage ongoing religious and spiritual support	• Facilitate access to religious support or spiritual sustenance.
Wider system involvement to develop cultural congruence	• Creation of better links and communication between traditional healers and religious leaders. • Sharing information and connecting with local communities. • Sharing resources (i.e., Figure 2 model) that reduce stigma and promote mental health literacy.

Discussion

4.1 Summary of findings

This review explored the psychosocial stressors and needs of SOPEP derived from qualitative studies. This narrative synthesis included studies outside western communities to explore SOPEP specific needs across diverse cultures and understand culturally specific psychosocial sibling-centred support. Most studies included provided clear details about the research, yet the researcher's own role was not often critically considered. All the studies included were deemed valuable research additions to existing literature, with findings important to consider in current practice and policy.

SOPEP play a key role in caregiving for their sibling and supporting their parents. This may result in SOPEP experiencing family tension, or impact on their socio-occupational functioning. Understandably, SOPEP may encounter a wide range of complex, layered emotions, and experiences, including guilt, shame, anger and increased psychological distress. The varying experiences of siblings may be understood by culture that shapes the values and perspectives of different communities. For example, some SOPEP may hold negative attitudes towards caregiving and perceive burden, negative impacts, and societal stigma. This may help services to understand why some parents shield patient's experiences from SOPEP, whilst others are involved with care from an early age. Some SOPEP make sacrifices within their personal lifestyle (e.g., family, career), whilst others distance themselves from their sibling.

Over half of the studies in this review discuss SOPEP need for knowledge and psychoeducation about topics including symptoms, aetiology, social welfare, legal and financial support. Of the four studies in this review exploring SOPEP at FEP and ARMS, all discuss the need to involve, support and share information with SOPEP, with three studies commenting on SOPEP dearth of information and understanding. Internet-based information and peer support intervention was found useful and acceptable to SOPEP in the UK (Sin et al., 2015). Providing SOPEP access to digital psychoeducation resources coupled with sibling peer support may benefit some families, although some may need additional support regarding social welfare, legal and financial advice with variations depending on one's culture, language, and localisation.

This review builds on the existing literature, highlighting the need for services to incorporate cultural adaptations. SOPEP beliefs and attitudes towards caregiving and mental health may be impacted by individual, social and macro-level factors, and their physical environment (see Figure 2). This review recognises the psychosocial stressors to caregiving and facilitators and barriers for SOPEP (e.g., resources and pragmatic challenges). Mental health services may wish to explore these six areas: SOPEP's beliefs about psychosis and caregiving, their family and cultural values, their personality traits (i.e., empathic, caring, patient), pragmatic challenges, and access to resources (see Table 3) when engaging with SOPEP to understand their caregiving demands and family cultural beliefs towards caregiving.

4.2. Clinical Implications

As symptoms of psychosis emerge this may impact the whole family (Wang et al., 2017), with siblings experiencing the cumulative effects of developmental challenges, combined with family disruption (Graves et al., 2020). The sibling bond is often the longest familial relationship in one's life (Day, 2020). Services may wish to consider additional support for SOPEP to feel less stressed, isolated, and confused about the psychosocial caregiving demands, and more positive and knowledgeable in how to support themselves and their sibling. Most studies in this review discuss emotional support for SOPEP, who may have mixed feelings and have questions about long-term caregiving responsibility. SOPEP involvement in family intervention or peer

support may provide them with a space to disclose difficult emotions towards their sibling or adopting a carer role and explore ways to facilitate caregiving.

Outdated language and cultural insensitivity may create barriers to minority groups engaging with mental health services. Understanding SOPEP's experiences and providing acceptable and effective culturally adapted interventions may facilitate their intentions and behaviours in providing care (see Figure 2). Tailored interventions may include exploring cultural values and family beliefs about psychosis and how they respond as a family or community. This may be crucial with some SOPEP from collectivist cultures involved in caregiving, some providing all care, whilst other may not be involved with expectations placed on parents (Napa et al., 2017; Seeman, 2013).

Understanding SOPEP' beliefs about caregiving may be important. These may vary depending on values, social stigma and experiences of discrimination. For example, some SOPEP may have additional responsibilities (e.g., their own family and children) but culturally expected to care for their sibling (Yang et al., 2017; Amaresha et al., 2015). Adapting services to SOPEP across the world may include clinicians providing psychoeducation about psychosis using *"simplified language"* and recognising SOPEP's beliefs (i.e., "*vamachara"* or a *"Jinn"* (Amaresha et al., 2015; 2019; Young & Flannigan., 2021; Al-Sawafi et al., 2021; 2022) or a message from G_d (Park & Lee, 2017)). This may help services to recognise that negative or positive emotional responses may be a result of the type of caregiving, resources, personal and identity factors (i.e., gender, geographic proximity, socioeconomics). Some SOPEP may need signposting to financial support as a carer if applicable to their culture. Clinicians should look to build trust with SOPEP from a non-judgmental position, learning from them and identifying their strengths and resources. Services may look to build connections with the community members (e.g., religious leaders, shamans, monks, traditional healers) to facilitate SOPEP's expectations of the caregiving role through religious support or spiritual sustenance, as well as reduce stigma, burden, and promote mental health literacy.

4.3. Limitations and Future Research

This review was the first to synthesise the psychosocial stressors of SOPEP across diverse cultures, whilst exploring the quality of the studies. The trainee included all the studies that met the inclusion criteria, irrelevant of quality. Justification for this was that the diverse forms of qualitative studies from varying cultures were deemed valuable contributions to existing literature, with findings important to consider in current practice and policy.

The review had certain limitations. The sample sizes within the studies were relatively small, and the trainee included studies with mixed samples of relatives (i.e., parents, partners, siblings, grandparents). Furthermore, the definition of *"sibling",* included step-, halfsiblings and uncles (Young & Flannigan, 2021). Combining samples from both the socially constructed phenomena of *"siblings"* and biologically defined *"siblings"* limits internal validity of the review. However, integrating the findings and acknowledging how SOPEP may vary across cultures and communities provides external validity. This may help to create culturally adaptable and acceptable interventions for SOPEP (Edge et al., 2018), as well as guide services to providing meaningful resources that meet the psychosocial needs of SOPEP and facilitate caregiving.

Future research exploring the psychosocial needs of SOPEP should give voice to siblings across more cultures, exploring the needs of younger and elder siblings and adopting rigorous qualitative and mixed methodologies. Exploring gender differences of SOPEP, their caregiving roles and psychosocial needs may help services to provide more acceptable support and engage SOPEP and families with mental health services earlier. Furthermore, most studies included focussed on chronic conditions, whereas future research may wish to explore early psychosis experiences (i.e., FEP, ARMS) and SOPEP's needs.

3.4.Conclusion

This qualitative review identified the needs of SOPEP, facilitators and barriers to providing support, and helpful resources to providing care. The review included the psychosocial stressors and needs of SOPEP across a variety of cultures and across the psychosis umbrella. SOPEP have strong emotional connections and compassion

towards their sibling and wanting to be a calming presence when socialising together. SOPEP involvement with caregiving may be within the family or they maintain all responsibilities, whilst also supporting their parents. SOPEP may experience negative emotions towards caregiving, their sibling and their family, feelings of burden and/or challenges to meeting their caregiving demands with their available resources. SOPEP's experiences were influenced by various stages: individual factors (e.g., knowledge, gender), social factors (e.g., education, family values), physical environments (e.g., access to community-based services), and macro-level environments (e.g., poverty, societal values). Connecting with local communities (e.g., religious leaders, traditional healers) in education programs may facilitate SOPEP's expectations of the caregiving role and reduce stigma and burden. Globally, SOPEP may benefit from involvement in family interventions and individual support that facilitates caregiving and acknowledges their psychosocial and emotional experiences.

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Chapter 2

Study 2 - Service Improvement Project: Understanding Barriers to Receiving Psychological Intervention for Older Persons in the Community, who Experience Distressing Hallucinations

Candidate: Emma Izon, Trainee Clinical Psychologist, The Oxford Institute of Clinical Psychology Training and Research. Email: emma.izon@hmc.ox.ac.uk

Internal Supervisor: Dr Alasdair Churchard, Research Tutor, The Oxford Institute of Clinical Psychology Training and Research, Oxford Health NHS Foundation Trust. Email: alasdair.churchard@hmc.ox.ac.uk

External Supervisor: Dr Rebecca Dow, Consultant Clinical Psychologist, Buckinghamshire Older People's Psychological Services, Oxford Health NHS Foundation Trust. Email: rebecca.dow@oxfordhealth.nhs.uk

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Proposed Journal: This manuscript is under review at *Nursing Older People.* This journal has been selected due to its focus on older persons and mental health problems, including schizophrenia and other psychoses. This journal was selected as it offers a forum for researchers in which service providers can submit new approaches and guidance that support the translation of research into evidence-based practice. This journal adheres to Harvard referencing style, for details, please see publish-with-rcni-author-guidelines-for-research-articles.pdf

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Title: Understanding Barriers to Receiving Psychological Intervention for Older Persons in the Community, who Experience Distressing Hallucinations.

Short Title: Hallucinations in Older Persons.

Abstract

The NHS 10-year plan aims to address inequalities in service provision, provide appropriate mental health support to all ages, and upskill healthcare professionals working in mental health community services. This research involved three phases: *Phase 1*– a clinical audit, *Phase 2*– a survey exploring the perceptions of mental health professionals in the service, and *Phase 3*– the Plan-Do-Study-Act improvement strategy. Between 2015-2021, only 6% of older persons with experiences of hallucinations were referred to psychological services, of whom only 1.3% received psychological interventions. Healthcare professionals within the community mental health team felt a combined psychological and pharmaceutical approach was most helpful for patients but were less confident referring patients to psychological services and discussing these benefits. Recommendations for services include utilising assessment tools to assess hallucinations in older persons, collaborating with third sector organisations and access to further training for healthcare professionals.

Key words: *older adults; hallucinations; psychosis; healthcare professionals; psychological intervention*

Introduction

The NHS (2019a) 10-year plan set out to adopt a more inclusive approach to care through early engagement and greater access to treatment choice. These plans include access to psychological therapies for older persons, who may be experiencing severe mental illnesses such as psychosis (NHS 2019a). NHS England (2019a) have prioritised supporting, training and upskilling healthcare professionals working in community mental health services to meet these objectives. The Community Mental Health Team (CMHT) transformation agenda (NHS 2022) aims to provide all those with severe and enduring illness access to specific types of psychotherapy, including Cognitive Behavioural Therapy for Psychosis (CBTp). Therefore, it is vital that services are responsive to older persons with mental health needs and healthcare professionals have the appropriate knowledge to facilitate these changes.

Psychotic symptoms are common among older persons and seen in a range of neurological, medical and psychological conditions, including dementia, Parkinson's disease, schizophrenia, brain tumours and thyroid disease (Karim and Byrne 2005). Hallucinations are perceptual experiences within a sensory modality but without the external stimulus (American Psychiatric Association, APA 2013) and vary in content, character, duration and quality. The prevalence of hallucinations in people older than 65 years of age without dementia ranges between 0.6 and 9% (Östling et al 2013; Soares et al 2015; Subramaniam et al 2016). Increased risk of developing psychotic symptoms in older persons has been associated with fewer years in education (Soares et al 2015), visual and hearing impairment, depression and irritability (Subramaniam et al 2016). There are substantial racial differences in psychotic symptoms reporting, with Asian older persons more likely to report symptoms than Westerners (Subramaniam et al 2016) and Black older persons three times more likely than their White counterparts (Cohen et al 2004).

Hallucinations are common in many conditions associated with older age, with specific prevalence rates varying by condition, stage of illness, and symptoms. For example, visual hallucinations are common in dementia and Parkinson's disease (O'Brien et al 2020), whilst auditory hallucinations are common in people with hearing loss (Linszen et al 2019). Distressing hallucinations can provoke anxiety, loneliness, anger and increase risk of falls and social withdrawal (Badcock et al

2020). Interventions include psychoeducation about hallucinations, psychological therapies, pharmacotherapy, risk management and physical therapy. Guidelines for treating hallucinations are managed within specific conditions, with limited acknowledgment of patient preference. For example, antipsychotic medications are often the first-line treatments for people living with dementia experiencing hallucinations (National Institute for Health and Care Excellence, NICE 2018). In contrast, schizophrenia clinical guidelines (NICE 2014) recommend antipsychotic medication in conjunction with psychological interventions (family intervention and individual cognitive behavioural therapy). Specialist Early Intervention to Psychosis (EIP) services supporting people with experiences such as hallucinations are typically not commissioned to support older persons, due to unlikelihood of them experiencing a first episode of psychosis. Older persons who experience distressing hallucinations are largely treated with pharmacological interventions, which can cause severe physical disability (Huybrechts et al 2012). Furthermore, the disparities between treatment of different conditions may create more inequality in engaging and treating hallucinatory symptoms in older persons.

In comparison to the general population, older persons are less likely to be referred to or receive psychological support (Age UK 2016). Barriers include older persons exhibiting fewer help-seeking behaviours (Age UK 2016), organisational constraints, for example, lack of resources, high caseloads and workload pressures on healthcare professionals (Ince et al 2016) and healthcare professionals acting as gatekeepers (Bennett et al 2017). Understanding mental health professionals' knowledge and beliefs can aid their training needs. Considering older persons report hallucinations across a range of settings (e.g., emergency departments, general admissions, long-term care), healthcare professionals require up-to-date knowledge, skills and training to meet patient's needs.

Service Context

South Buckinghamshire covers 60% of the Buckinghamshire region. According to the latest 2021 census (Office for National Statistics 2023), the population of Buckinghamshire is 555,257. The Buckinghamshire population is predominantly White (80%), with Asian people representing the largest minority population (12.4%). Life expectancy of someone born today in Buckinghamshire is 83 years, compared to

81 years in England as a whole. The largest religious group in Buckinghamshire is Christians (47%). English is spoken as the main language by 92.7%, with a small proportion having poor English language skills (1%) or unable to speak English (0.2%).

The community mental health team (CMHT) supports people aged 65 years and older with mental illness. The team consists of thirty mental health professionals across a range of professional disciplines: psychiatrists, junior doctors, nurses, social workers, support workers, occupational therapists, clinical psychologists and assistant psychologists. A psychology team sits within the community mental health team. Bi-weekly multi-disciplinary team meetings involve case discussion of clinical patients and approaches to care; clinical psychologists within the team attend these to encourage team psychological mindedness. On 4th March 2021, the South Buckinghamshire Older Persons CMHT service held 446 patients. In the three years prior to this date, the consultant clinical psychologist was aware of only one referral to psychological therapy of an older person with experiences of hallucinations.

Meetings between the trainee, clinical lead for Oxford Health and service consultant clinical psychologist highlighted gaps between those offered psychological interventions and experiences of hallucinations, which is particularly important with the increase in funding and NHS-plan (2019a). During the development of this project, clinical discussions between the trainee and psychology consultants highlighted how MDT meetings focussed on the person's experiences of hallucinations as organic and "*incurable*", or the person was perceived to be "*in crisis*", so treatment prioritised pharmacological interventions. This reflects the current state of older persons services, whereby the medical model may be the prioritised line of treatment (Healthcare Commission 2009). This raises multiple questions, whether healthcare professionals are routinely asking older persons about psychological wellbeing, providing them multiple opportunities to disclose distress associated with hallucinations, or whether healthcare professionals too perceive barriers to psychological intervention (Badcock et al 2020; Berry et al 2020).

Aims

This study aimed to explore barriers to accessing psychological support for older persons experiencing hallucinations.

Research objectives:

1. Retrospectively audit the number of patients in the South Buckinghamshire older persons CMHT who experience hallucinations and received psychological therapy from 2015-2021. Investigate of those persons, the number who fell into a psychosis cluster diagnosis and were referred to psychological services.
2. Explore the community mental health teams' understanding of factors that contribute to the development of hallucinations in older persons, their beliefs about treatment and confidence working with these symptoms.
3. Utilise the Plan-Do-Study-Act (PDSA) improvement strategy (Speroff and O'Connor 2004) to identify recommendations.

Ethical Approval

This audit was granted local NHS audit approval as quality improvement research and accessed patient information through the local clinical notes system over a six-year period (see Appendix E).

Methods

Design

The three phases: *Phase 1*– an investigation and audit, *Phase 2*– exploring the perceptions of mental health professionals in the service through questionnaires, and *Phase 3*– a PDSA improvement strategy.

Phase 1. Clinical Audit

An audit of the service would convey the number of older patients who disclosed or discussed their hallucinations and/or accessed psychological support. Data were drawn from Case Records Interactive Search (CRIS), a database of de-identified electronic health records (EHRs) from Oxford Health Foundation Trust NHS. The CRIS database allows researchers to access structured data (e.g., demographic data) and unstructured data (e.g., free text entered by healthcare professionals based on

clinical encounters) for mental health research, service evaluations and clinical audits (Oxford Health 2023). The CRIS database was developed with extensive service user involvement and adheres to strict governance frameworks managed by service users. Data are used in an entirely de-identified and secure format and all patients have the choice to opt-out of their de-identified data being used (Oxford Health 2023). The trainee registered the audit with CRIS, which was reviewed by a CRIS Oversight Group. On approval, to generate data, the term "*hallucination*" was first operationalised to include terms with and without hallucination experiences (see Appendix F). CRIS was utilised to access information within "*Outcomes*" and "*Patient info*" on Carenotes and was able to explore patient "*correspondence*" and "*clinical notes*" over a six-year period (07/01/2015-02/02/2021).

Phase 2. Questionnaire

A questionnaire (see Appendix G) was created from background literature and consultations with six clinicians. Their recommendations resulted in questionnaire refinement, for example clearer wording, additional questions exploring misconceptions on psychological intervention and previous engagement in referrals. Thirty mental health professionals working in the service were approached using opportunistic sampling to complete the questionnaire about older persons (aged 65+) experiencing hallucinations. Mental health professionals in the service had the opportunity to complete the questionnaire in person or online. To reduce social desirability and preserve honesty and integrity, the questionnaire preserved participant confidentiality and anonymity. Analysis was conducted using SPSSv27.

Phase 3. Plan-Do-Study-Act (PDSA)

Quality improvement (QI) methodology was implemented using a PDSA cycle with a time-series (AB) design (Speroff and O'Connor 2004). In the "*plan*" phase, further discussions with the clinical lead for Oxford Health and service consultant clinical psychologist led us to hypothesise that training around hallucinations and the psychology referral procedure would lead to an improvement in the confidence of healthcare professionals in the service and increase referral frequency. The "*do*" phase involved training. The "*study"* phase involved post training discussion between the trainee and the service consultant, and the "*act"* phase identified recommendations.

Training

Training adopted Bennett-Levy and Thwaites's (2007) *declarative–procedural–reflective model* as a theoretical framework. This framework complements diverse professions, for example nursing, with continued learning with emerging developments in health and care, whilst reflecting on one's own practice (Nursing and Midwifery Council, NMC 2018). Participants were educated about hallucinations, clarification of myths (recognised from the questionnaire), the evidence base for psychological intervention and how it can help (e.g., stress reduction). Training emphasised participants' transferable skills in engaging patients. For example, non-judgmental attitudes and behaviours to encourage self-reporting and alleviate distress for older persons. As well as using non-stigmatising language with older persons and their carers and providing accurate information. General reflections from the demands of the service (high caseloads, high staff turnover and burnout), as well as individual reflections (participants' beliefs, experiences, and feelings) impacting on their language and engagement with older persons were encouraged. To acknowledge the length of training (20-minutes) and limited discussion of cases, additional resources were provided.

Results

Phase 1. Clinical Audit

Between 2015-2021, the South Buckinghamshire Older Persons CMHT service reported 622 general entries of the term "*hallucinations*". These were typically recorded in "*Clinical Notes*" and found in "*Attachments*" (i.e., GP letters and referral letters). Nursing staff made most entries and reports. From the 622 entries, duplicates of patients were removed to deduce 317 patients reported experiences of "*hallucinations*"; of whom, 24% fell into a psychosis cluster diagnosis. Of the 317 patients, 19 (5.99%) were referred to psychological services, of whom, 2% fell into a psychosis cluster diagnosis. Four of the 317 patients (1.3%) received psychological intervention: three received individual therapy, and one systemic therapy.

Table 4 includes the demographic details of those referred and not referred to psychological services and the total number between 07/01/2015-02/02/2021. The mean age (79 years) was the same in both groups, however the age range was wider for those that were not referred to psychological services. Participants' ethnicity was

unknown (52%) or White British (40%), with sparse numbers of other ethnicities reported. Of the total population, approximately one quarter fell into a psychosis cluster, whilst the majority fell into the dementia diagnoses.

Table 4. Demographic details of older persons experiencing hallucinations who were referred to psychological services between 07/01/2015-02/02/2021

	Referrals (*n* = 19)	**Not referred** (*n* = 298)	**Total** (*n* = 317)
Age at referral (years)			
Mean	79	79	79
Range	62-94	31-99	31-99
Gender			
Male (%)	9 (47.37)	115 (38.59)	124 (39.12)
Ethnicity			
White British	6 (31.58%)	119 (39.9%)	125 (39.43%)
White Other	0	9 (3.0%)	9 (2.84%)
Asian or Asian British	0	9 (3.0%)	9 (2.84%)
Black or Black British	0	5 (1.68%)	5 (1.58%)
Any other group	0	1 (0.34%)	1 (0.32%)
Not known†	13 (68.42%)	155 (52.0%)	168 (53.00%)
Diagnosis			
Psychotic Features (F20.0, F20.9, F32.3)	7 (36.84%)	69 (23.15%)	76 (23.9%)
Dementia (F000.0, F000.1, F000.2, F01.2, F02.3, F03)	8 (42.11%)	126 (42.28%)	134 (42.27%)
Cognitive Dysfunction (F06.7, F06.8)	0	24 (8.05%)	24 (7.57%)
Delirium (F05.9)	0	4 (1.34%)	4 (1.26%)
Affective Disorders (F32.1, F33.4, F39)	3 (15.89%)	26 (8.72%)	29 (9.15%)
Anxiety Disorders (F41.1)	1 (5.26%)	16 (5.37%)	17 (5.36%)
Substance Use (F10.0, F10.1, F10.3, F04X)	0	6 (2.01%)	6 (1.89%)
Not otherwise specified (F99.X)	0	3 (1.01%)	3 (0.95%)
Physical Health (S72.9, C50.9)	0	6 (2.01%)	6 (1.89%)
Not Known†	0	18 (6.04%)	18 (5.68%)

Note. †Missing data due to information not requested and/or patient refusal

The age range (31-99 years) includes clients who accessed mental health services for neurological assessments.

Phase 2. Questionnaire

Eighteen of thirty mental health professionals working within the community mental health team (with people aged 65+ years with mental illness) completed the questionnaire. (see Appendix G). Demographic details of those who completed the

survey can be seen in Table 5. Over 60% of healthcare professionals who completed the questionnaire had worked in the service for less than one year.

Table 5. Demographics of mental health professionals working in the community mental health team with people aged 65+ years with mental illness

Demographics	***n* = 18 (%)**
Age (*n* = 16)	
Mean, Range	37.63, 19-60
Gender (*n* = 16)	
Female (%)	13 (81.25)
Job Role (*n* = 17)	
Occupational Therapist	3 (17.6)
Psychiatrist	2 (11.8)
Support Worker	1 (5.9)
Social Worker	2 (11.8)
Community Psychiatric Nurses	3 (17.6)
Assistant Psychologists	2 (11.8)
Other (e.g., student nurse)	4 (23.5)
Time in the role (*n* = 18)	
< 1 year	11 (61.1)
1-2 years	2 (11.1)
3-5 years	1 (5.6)
> 10 years	4 (22.2)

Mental health professionals rated highly on feeling completely comfortable asking patients about their experiences of hallucinations (see Table 6). Although over 90% considered psychological intervention as a helpful treatment, only 29% had referred an older person with distressing hallucinations to psychological therapies and 40% were not completely comfortable referring someone (see Table 6).

Table 6. The views of eighteen of thirty healthcare professionals working in the community mental health team with people aged 65+ years with mental illness

Healthcare Professionals' Experiences and Views	***N* (%)**
Frequency asking patients about hallucinations (*n* = 16)	
At assessment only	10 (62.5)
Every contact	4 (25)
I don't ask	2 (12.5)
Comfortable asking patients (*n* = 16)	
Completely comfortable	13 (81.25)
Not comfortable	1 (6.25)
Unsure	2 (12.5)
Psychology considered helpful (*n* = 16)	
yes	15 (93.75)
Prior referrals made to psychology (*n* = 17)	
yes	5 (29.4)
Comfortable referring to psychology (*n* = 15)	
Completely comfortable	9 (60)
Not comfortable	2 (13.3)
Unsure	4 (26.7)

Mental health professionals rated a combined treatment of medication and psychological therapies as the most helpful, followed by pharmaceutical intervention alone, and subsequently psychological intervention alone (see Figure 3). Mental health professionals working within the community mental health team were predominantly confident working with older persons experiencing hallucinations. They reported feeling confident referring someone to psychological therapies, however, they were less confident explaining and discussing the pros and cons of the intervention with patients. The mean agreement shared between the mental health professionals was the waitlist for psychological therapies was too long (50%), psychological intervention could result in no improvement (29%) or even cause more harm (29%).

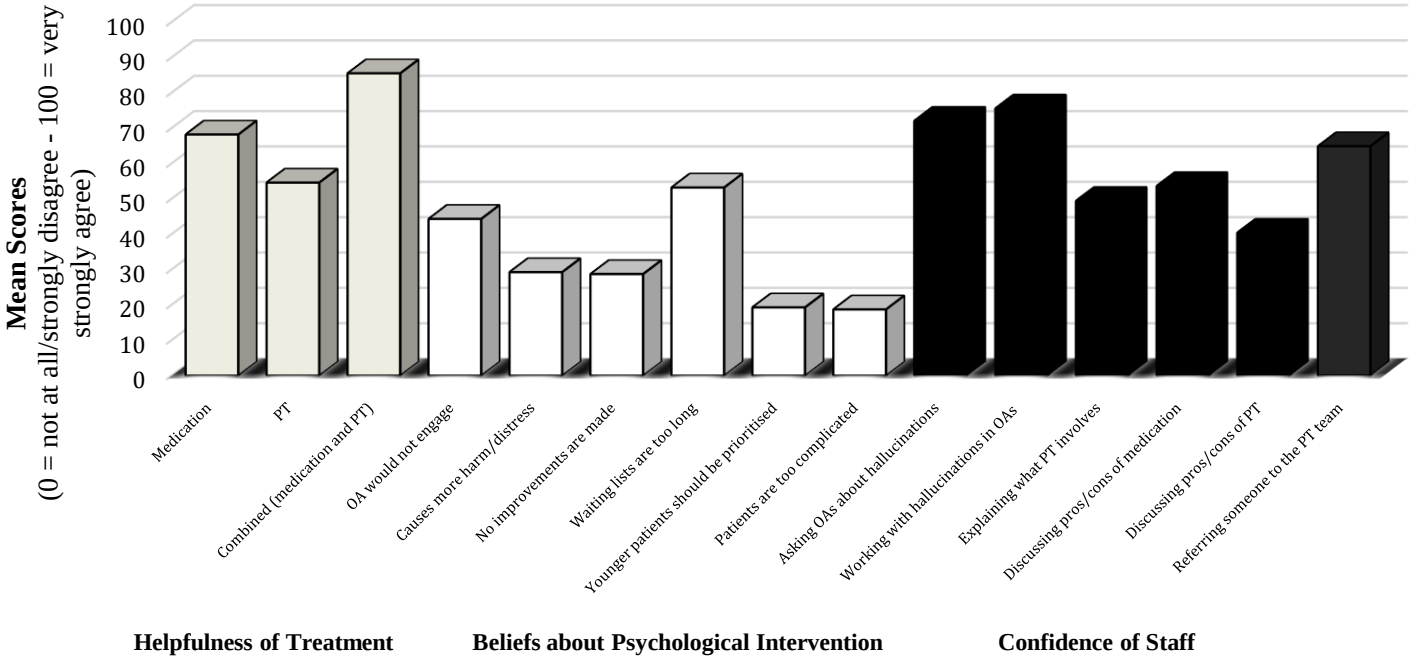


Figure 3. The mean scores of healthcare professionals (*n* = 18) within the older persons service and their perspectives of patients who experience distressing hallucinations

Abbreviations: OA = Older Adults; PT = psychological therapies.

The graph separates healthcare professionals from the South Buckinghamshire Older Persons Community Mental Health Team's perspectives. The first three (grey) bars explore how helpful healthcare professionals find treatment, the next six (white) bars explore their beliefs about psychological intervention, and the final six (black) bars their confidence.

There was a high level of agreement between mental health professionals in the service on factors that may contribute towards the development of hallucinations for older persons (see Figure 4). Chemical imbalances in the brain or brain disease alongside traumatic events in adulthood and childhood were most highly rated in contributing towards the development of hallucinations in older persons.

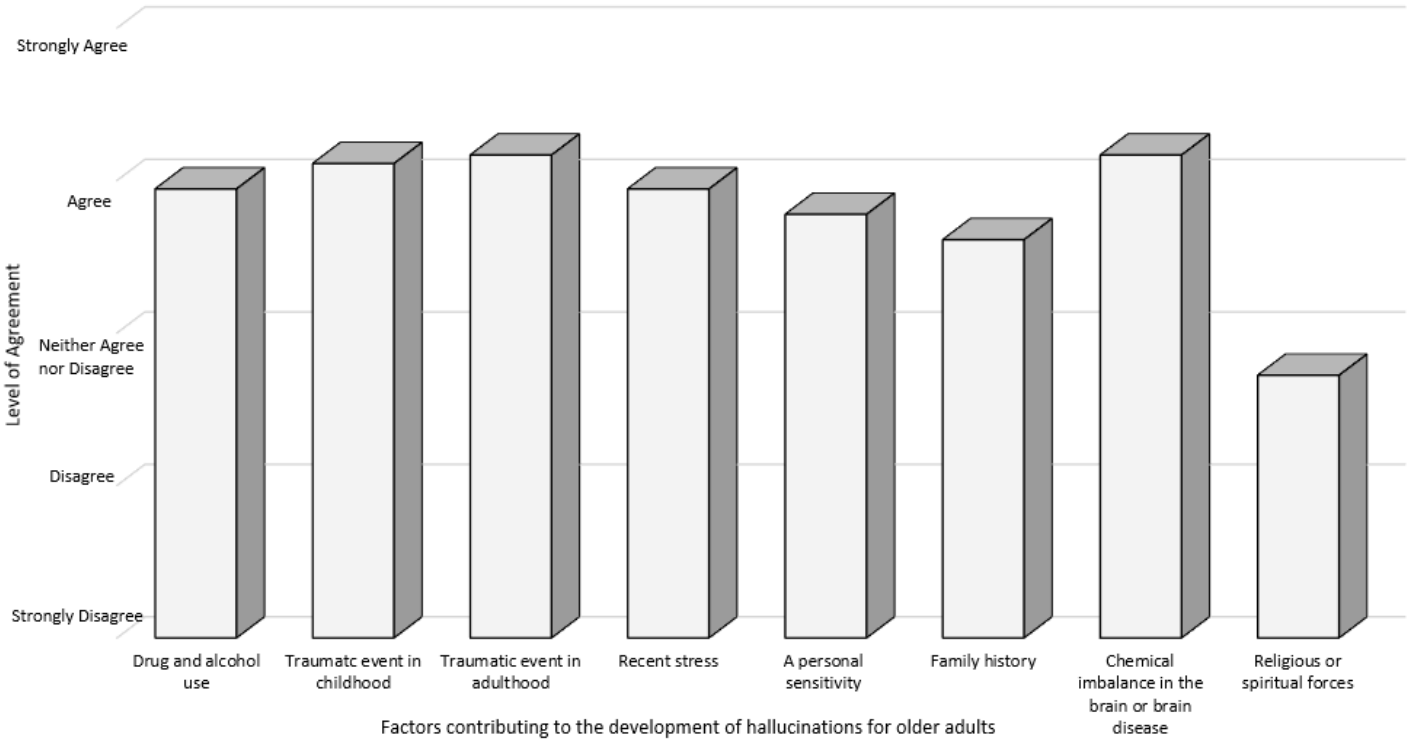


Figure 4. Mean level of agreement on factors contributing to the development of hallucinations for older persons

The graph displays the mean level of agreement (from strongly disagree to strongly agree) for healthcare professionals from the South Buckinghamshire Older Persons Team on their beliefs of factors that contribute to the development of hallucinations in older persons.

Phase 3. PDSA

The training took place and was attended by twenty-five mental health professionals across Buckinghamshire Older Adult services.

Discussion

This research involved three phases to help understand barriers to receiving psychological intervention for older persons (in community mental health teams) experiencing distressing hallucinations. The audit conducted between 2015-2021 found approximately 6% of patients with experiences of hallucinations in the service were referred to psychological services, of whom only 1.3% received psychological interventions. Understanding the perspectives of mental health professionals within the teams could guide further training. Consequently, resulting in long-term benefits

to increase professionals' psychological mindedness and increasing access to psychological interventions for older persons. Healthcare professionals reported feeling confident referring someone to psychological therapies, however, less confident explaining and discussing the pros and cons of psychological interventions. The average agreement score between mental health professionals in the service suggested a small percentage of agreement that psychological intervention could result in no improvement or even cause more harm. Training that utilised a declarative–procedural–reflective framework was well attended by healthcare professionals in the service. The research findings demonstrate the importance of ongoing access to training for healthcare professionals around psychological interventions for older persons with experiences of hallucinations.

Phase 1. Clinical Audit

The audit highlighted potential barriers within the service for older persons with hallucinations in accessing psychological therapies. As previously mentioned, hallucinations are managed within specific conditions, with disparities in recommended treatment (e.g., dementia and psychosis). One explanation may be healthcare professionals lack the knowledge that hallucinations can occur in the absence of a diagnosis of mental illness and psychological intervention can be helpful in reducing distress (Paulik et al 2019). Alternatively, older persons' perceptions of psychological therapy may be based on historical context around the nature and course of treatments, thus being less likely to engage in psychological intervention (Boddington 2014). As this audit was completed during the COVID-19 pandemic, older persons had less access to psychological intervention. Older persons' prior experience with technology, salience of psychological intervention to the person and their family may facilitate psychological engagement. Furthermore, adult services may retain patients with long-term diagnoses longer, and transfer them later to older persons' services.

Phase 2. Questionnaire

Healthcare professionals in the team considered psychological intervention helpful for older persons experiencing hallucinations. Disparities in their confidence and skills were seen between talking to patients about their experiences with discussing psychological interventions for hallucinations. Almost half of healthcare professionals

were not completely comfortable referring someone to psychology. As identified by the questionnaire, healthcare professionals felt the waitlist for psychological therapies was too long, whilst others held a belief that psychological intervention may result in no improvements or harm patients. It is important to consider the context of the COVID-19 pandemic when the questionnaire was distributed, as the service was experiencing a high amount of staff turnover and absence due to ill health. Newer members of the team may have an absence of knowledge (e.g., referring to psychology, psychological intervention for hallucinations in older persons across conditions) as they lacked experience in their role. Meanwhile, more established team members may have focussed on symptom reduction and risk management rather than recovery, consequently impacting referrals to psychological therapies.

Healthcare professionals rated a combined treatment most helpful, followed by pharmaceutical interventions. These findings may be a result of the gap in knowledge around psychological therapies, with participants rating higher confidence discussing the pros and cons of medication. These findings endorse the NHS plans for upskilling staff with knowledge and skills (2019a) and providing needs-based learning around psychological support.

There was high agreement between healthcare professionals on biological-psychological-social factors that can contribute towards the development of hallucinations for older persons. Chemical imbalances in the brain or brain disease alongside traumatic events in adulthood and childhood were most highly rated. Clinicians' aetiological beliefs about the cause of hallucinations and psychosis have been associated with their perceptions about the helpfulness of treatment (Carter et al 2017). This may explain why case notes of hallucinatory experiences predominantly involved patients with a diagnosis of dementia or psychotic features, and influence referrals to psychological therapies within conditions. Enhancing professionals' knowledge around hallucinations in other medical and psychological conditions (e.g., Parkinson's disease, brain tumours and thyroid disease) and how psychological interventions can reduce distress (Paulik et al 2019) may result in increased referrals to psychological therapies.

Phase 3. PDSA

Training included psychoeducation around hallucinations, the psychological evidence base, identified transferable skills healthcare professionals held in engaging patients and created space for participants to reflect on their complex and demanding workloads. Expert feedback and reflective discussions in training can reduce mistakes and clinical errors (Bradley et al 2022). Facilitating reflection has been found to improve clinical practice and reduce burnout in staff (Bennett-Levy and Thwaites 2007) and was deemed acceptable to healthcare professionals following the COVID-19 pandemic.

Implications

The results and findings were disseminated through emails and meetings with key stakeholders, the service manager and clinical lead. In March 2022, the trainee presented the findings from Phases One and Two to a national audience at the Faculty of the Psychology of Older People symposium (FPOP; BPS 2022).

The trainee met with the clinical lead for Oxford Health, service manager and consultant clinical psychologist to disseminate findings and discuss how recommendations may be implemented. At the training (phase 3), healthcare professionals within the team suggested that barriers to referrals to psychological interventions were maintained by resource constraints, appropriate training, and access to MDT integrated working. In line with NHS England (2019a; 2019b), effective training should look to upskill healthcare workers in psychological therapies. Training that provides psychoeducation that includes aetiological evidence-based information about hallucinations, recognises healthcare professionals predisposed skills and strengths, whilst creating a reflective space may enhance interpersonal skills of workers and improve care of patients. Additional recommendations emerged from the training (see Table 7) to support healthcare professionals' skills, enhance their knowledge and psychological mindedness. These recommendations may positively benefit patient outcomes and improve access to psychological support for older persons.

Table 7. Summary of recommendations rationale

	Recommendations	**Rationale**	**Excerpts and evidence from healthcare professionals training**
1.	Script or assessment tool for healthcare professionals when asking older persons about hallucinations.	To aid healthcare professionals in recognising and normalising hallucinatory experiences for older persons, build confidence, service user rapport, trust and normalise patient experiences.	"*It would have been helpful to talk about how to have these conversations- to move beyond empathising and validating to touch on HOW these questions can be asked. E.g., what to do if the person asks directly if we believe them?"*
2.	A guide for healthcare professionals on what psychological services would need to know about older persons with hallucinations and the types of patients they accept at referral. A loose inclusion/exclusion guide.	Provide a consistent message of what is important to be aware of when thinking about referring older persons with hallucinations to psychological therapies.	*"I feel as though psychology will not accept referrals for particularly difficult/challenging patients, including those experiencing hallucinations… Maybe a bit of information around the 'type of patients' psychology will accept."*
3.	To collaborate and link up with third sector organisations (e.g., The Hearing Voices Network) to access additional training needs.	Further need to incorporate destigmatising, demystifying information and reducing stigma.	Mixed response with some who preferred a shorter session, *"I enjoy shorter sessions like the one today, a lot easier to engage with and concentrate throughout"*, whilst others valued longer training *"Would be more beneficial if it was longer and more in depth".*
4.	Psychological Training for healthcare professionals (access to relevant resources).	Improve psychological mindedness within the service and skills, which fits with the CMHT transformation policy (NHS 2019b).	Training was deemed to support this need *"Very interesting and feel more confident about what hallucinations are, what psychology can offer, and how I can support patients who may be experiencing hallucinations."* When asked what healthcare professionals would like access to in the future, almost half attendees responded more training and access to resources.
5.	Psychological services maintaining contact and transparency with around waiting lists.	Long waiting times are associated with poor motivation, poor engagement, and higher levels of non-attendance	*"Technically this is all fine and well but, when to refer here to the psychology dept... Ideally great the lecture but pragmatism will*

	(Westin et al 2014), which can impact therapeutic outcomes, and likelihood of referral.	*deter one to change anything sadly."*

Strengths, Limitations and Future Research Recommendations

This novel research explored barriers to accessing psychological support for older persons experiencing hallucinations within a community mental health team. The research emphasised the value of healthcare professionals' perspectives in providing service-specific training and service development. The findings highlight the importance of healthcare professionals having knowledge around psychological interventions and the evidence base across different conditions where hallucinations in older persons occur.

Healthcare professionals who completed the research and training were from one single service in the South of England, with varying backgrounds in education, training and experiences. Therefore, the findings limit generalisability to all professions and cultures. Future research should consider systematically exploring the experiences of healthcare professionals and older persons through in-depth qualitative interviews. Furthermore, exploring how training impacts on healthcare professionals' confidence in referring to psychological therapies, as well as changes in referral rates would be an important outcome for future research.

Furthermore, considering six of the 19 older persons referred to psychology were White British, whilst the remaining 13 persons' ethnicity was unknown, it would be important to monitor this within the service, explore patient demographics in other conditions to understand the context of referrals and outcomes for minority ethnic groups.

Conclusion

The three-phase research project explored barriers to older persons accessing psychological therapies within a community mental health team. *Phase 1*– a clinical audit, *Phase 2*– the survey exploring healthcare professionals' perceptions, and *Phase 3*– a Plan-Do-Study-Act (PDSA) improvement strategy. Between 2015-2021, only 6% of patients with experiences of hallucinations were referred to psychological services, of whom only 1.3% received psychological interventions. Healthcare

professionals in the team did not feel confident discussing the benefits or referring patients to psychological therapies. Training was well attended and acknowledged healthcare professionals' skills, provided a reflective space and psychoeducation around referring older persons with distressing hallucinations to psychological services. Recommendations for services include utilising assessment tools to assess hallucinations in older persons, collaborating with third sector organisations and accessing further training for healthcare professionals. Considering older persons report hallucinations across a range of settings, healthcare professionals should look to access up-to-date knowledge, skills and training to meet patient's needs, improve outcomes and access to psychological support for older persons.

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Chapter 3

Study 3 - Theory Driven Research Project (TDRP): Investigating Sexual Orientation Concealment and Psychological Health in an Ethno-religious LGBTQ+ Jewish Group and Non-religious LGBTQ+ Group.

Candidate: Emma Izon, Trainee Clinical Psychologist, The Oxford Institute of Clinical Psychology Training and Research. Email: emma.izon@hmc.ox.ac.uk

Internal Supervisor: Dr Fiona McFarlane, Clinical Psychologist, The Oxford Institute of Clinical Psychology Training and Research, The Oxford Centre for Psychological Health, Oxford Health NHS Foundation Trust.
Email: fiona.mcFarlane@hmc.ox.ac.uk

External Supervisor: Dr Joanna Semlyen, Associate Professor & Chartered Health Psychologist, University of East Anglia. Email: j.semlyen@uea.ac.uk

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Proposed Journal: This manuscript will be submitted to *Psychology of Sexual Orientation and Gender Diversity*. This journal has been selected due to aims and scope to address the unique experiences of LGBTQ+ individuals in the context of the complexities, nuances, and the multifaceted aspects of sexuality and gender. The journal focuses on empirical research and highlights the importance of theory, research and practice in the psychology of sexual orientation, as well as initiation to support equality, diversity and inclusion. The journal requires authors to provide information for the general public, facilitating further dissemination of the research. This journal adheres to APA referencing style, for details, please see https://www.apa.org/pubs/journals/sgd

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Conflict of Interest

This work was supported by the Oxford Institute for Clinical Psychology Training and Research. No funding was sought for this project. The authors note no conflicts of interest.

Title: Investigating Sexual Orientation Concealment and Psychological Health in an Ethno-religious LGBTQ+ Jewish Group and Non-religious LGBTQ+ Group.

Short Title: Sexual Orientation Concealment and Psychological Health.

Abstract

Background An individual's relationship with sexuality and religion may be complex, particularly when these principles conflict. According to Minority Stress Theory, people from minority groups (e.g., religion, sexuality) can experience excess stress, which may contribute towards psychological distress. LGBTQ+ people living in more stigmatising environments may therefore seek to conceal their sexual orientation and this can negatively impact their mental health. **Aim** This study looked to investigate sexual identity concealment in an ethno-religious Jewish LGBTQ+ population. **Methods** The experiences of concealment of Jewish LGBTQ+ were compared with a non-religious LGBTQ+ group. Information about participants' concealment behaviour and their psychological health was collected, alongside participants' Jewish identity. **Results** Concealment was higher in the non-religious LGBTQ+ group compared to the Jewish LGBTQ+ group, although overall mental health was significantly poorer in the Jewish group. The study did not find concealment to predict mental health. Within the Jewish group, LGBTQ+ individuals who identified as more culturally and religiously Jewish concealed more. **Discussion** Other processes may better predict mental health for this population. Minority Stress Theory suggest this may be due to proximal stressors, such as expectations of rejection or internalised homophobia. Meanwhile, the importance of Jewish cultural and family values over religious practice may explain participants' openness about their sexual orientation. There is a need for qualitative research to explore the impact on and purpose of concealment for Jewish LGBTQ+. There is also a need for more quantitative research to better understand the experiences that contribute towards mental health difficulties for LGBTQ+ Jews and how services can meet this need.

Key words: *identity, concealment, minoritised groups, Jewish, sexuality, LGBTQ+*

Abbreviations*:* Lesbian, Gay, Bisexual, Transgender, Queer, plus individuals from other minority sexual groups = LGBTQ+; Trans and Other = TAO.

Introduction

Understanding the experiences of people of faith from Lesbian, Gay, Bisexual, Transgender, Queer, plus individuals from other minority sexual groups (LGBTQ+) may help develop targeted support and improve referral pathways for this population known to experience additional and cumulative stressors (Department of Health, 2005; Huang et al., 2020; Silveri et al., 2022). This paper begins by providing context about British Jews and the view of sexuality within the religion. Subsequently, minority stress theory will be introduced, with a focus on the process of concealment, a summary of the key findings within the literature of sexuality and people of faith will provide context to the experiences of concealment and poor mental health in this population. To the authors knowledge, there has been no study exploring concealment in Jewish LGBTQ+ individuals in the UK. The authors discuss the aims of the current study and how they would explore the relationship between general psychological health and concealment for UK Jews.

British-Jews

According to the Race-Relations Act (1976), British-Jews are considered an ethno-religious group. The Office of National Statistics (Graham & Boyd, 2022) found British-Jews make 0.5% of the UK population (with 43.2% no religion affiliation or unstated), representing the fifth largest Jewish community in the world. Denominations exist within the Jewish community that differ regarding their religious philosophy and practice.

Orthodox Judaism holds the principle of "*Torah min ha-shamayim*" or "*Torah from heaven*", which signifies a belief that the commandments of Torah have been divinely revealed and are therefore indisputable (Goldberg & Rayner, 1989). In comparison, Progressive Judaism views the Torah as divinely inspired, with some elements open to revision considering modern scholarship (Stern, n.d.). Some British-Jews have little or no contact with a synagogue but still maintain a Jewish cultural identity, based upon certain values and expectations, such as the importance of the traditional family (Coyle & Rafalin, 2000).

Religious affiliation and identity can act as a protective factor for mental health difficulties, foster resilience to psychological distress (Harari et al., 2014), and

provide a sense of meaning, community and social support (Koenig et al., 2012). However, present and historical climates continue and have created tension for British-Jews (Mann, 2023), for example, trans-generational trauma from the Holocaust, past attempts to persecute and eradicate the Jewish people and present-day antisemitism. Furthermore, cultural and generational expectations persist to ensure the continued existence of the Jewish race through marriage and childbearing (Unterman, 1995).

Judaism and Sexuality

Orthodox Judaism interprets same-gender acts as incompatible with living a religious life, *"you shall not lie with a man as one lies with a woman"* (The Chumash, 1993). Homosexuality is prohibited for both men and women, whilst the moral, social, and religious consequences are considered more severe for men (Shilo et al., 2016). Orthodox LGBTQ+ individuals, particularly gay and bisexual men may experience heightened identity conflict (Shilo et al., 2016). Religious congregations' socio-cultural values and expectations may create further conflict and mental distress for people of religious and sexual minority (Shilo et al., 2016). When exploring openness towards their sexuality, religious gay and bisexual Jews were more likely to conceal their sexual orientation from family and close friends (Shilo et al., 2016), in comparison to secular sexual minorities of Jews (Shilo & Mor, 2014; Shilo & Savaya, 2012).

Minority Stress Theory

People from minoritised groups (e.g., religion, sexuality) can experience excess stress due to "*the relationship between minority and dominant values and resultant conflict with the social environment*" (Meyer, 1995, p.39). Meyer's (2003) model (see Figure 5) ascribes minority stress as: (a) *unique*–accumulative to the usual stress experienced by people who are not stigmatised, (b) *chronic*–related to stable social and cultural structures and (c) *socially based*–established from social processes, institutions, and structures. Minority stress is observed in many stigmatised identities, because of harassment, maltreatment, and discrimination (Meyer, 2003; Marshal et al., 2008).

Increased exposure to minority stressors may contribute toward psychological distress, poorer mental health outcomes (Meyer, 2003; Wallace et al., 2016) and

impoverished health care (Semlyen et al., 2018). Elevated levels of psychological distress in sexual minority populations can be explained by experiences of social hazards associated with sexual minority status, leading to adverse mental health consequences (Chae & Ayala, 2009). LGBTQ+ individuals are more likely than heterosexual counterparts to experience psychological distress (Jones et al., 2017), engage in self-harm behaviours and die by suicide (King et al., 2008; Semlyen et al., 2016; Johns et al., 2018), albeit dependent on their socio-cultural and political context (Lim & Herwitt, 2018).

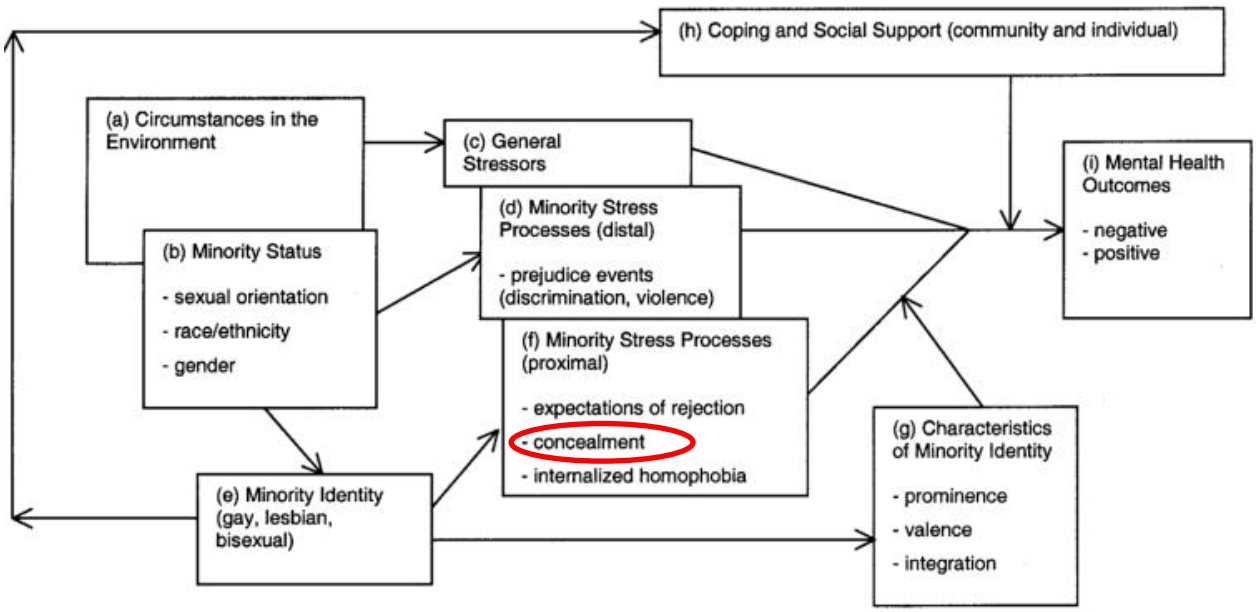


Figure 5. Minority stress process in lesbian, gay and bisexual populations (Meyer, 2003).

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Concealment "lack of open behaviour"

The minority stress model (Figure 5) describes processes that may operate in LGBTQ+ populations. The model displays how hostile and stressful social environments alongside minority stress processes may contribute towards mental health problems.

One process highlighted by the authors is concealment. Concealment refers to a behavioural construct informed by cognitive factors (Pachankis, 2007). Concealment

is not a single event but specifically conceptualised dependent on the questions asked (Sandfort et al., 2018). Sexual orientation concealment refers to the absence of *"an active indication of one's sexual orientation through speech or action"* (Meidlinger & Hope, 2014; p. 490). Paradoxically, concealing one's identity is often used as a coping strategy (e.g., avoiding consequences of stigma, harm, shame and guilt) but according to Meyer's (2003) model, concealing can negatively impact one's wellbeing. LGBTQ+ people living in more stigmatising environments may be more likely to conceal their sexual orientation (Pachankis & Bränström, 2018). The most recent meta-analysis review exploring sexual orientation concealment found *"lack of open behaviour"* showed strong associations between concealment and internalising mental health problems (Altman & Royston, 2006; Pachankis et al., 2020).

LGBTQ+ Jewish individuals in the UK may also choose to conceal their religious identity within the LGBTQ+ community (Switchboard, 2019). LGBTQ+ Jewish individuals have reported experiences within the LGBTQ+ community of racial and ethnic discrimination, antisemitism and feeling less accepted (Switchboard, 2019; Fox et al., 2019; Abu-Ras et al., 2021). Some people may have multiple different minority identities (commonly referred to as intersectional identities) and face a multiplicity of social barriers and trauma (e.g., racism and heterosexism), with accompanying and compounding health effects (Wilson & Yoshikawa, 2007). Within the sociocultural context of UK-Jews, queer identity challenges established familial, communal and religious scripts (Unterman, 1995; Goldberg & Rayner, 1989). Despite the prevalence of these conflicts, our knowledge of how UK queer Jews navigate religion, family and community remains limited.

Recent Research

LGBTQ+ people of faith can experience faith related negative stressors (e.g., discrimination, internalised homophobia; Reisen et al., 2001; Kulick et al., 2017). The prevailing narrative that LGBTQ+ identity and faith *'do not mix'* and are antagonistic is rooted in long-standing discrimination against LGBTQ+ people in some faith communities, e.g., views around conversion therapies (Switchboard, 2019).

A recent review found concealment of sexuality was associated with poorer mental health and wellbeing, although the majority of these studies included experiences of

Americans and people of Christian faith (McCann et al., 2020). Perceived negative attitudes towards homosexuality can result in religious lesbian, gay and bisexual people concealing their sexual identity, for fear of isolation, family rejection and negative social consequences (Shilo & Savaya, 2012). Etengoff & Rodriguez (2021) study further supports these findings; they found lesbian Muslim women reported higher levels of concealment to their family and friends in comparison to a broader population of gay men and women (Mohr and Fassinger, 2000). These participants reported severe depression when describing changes in their familial relationships, due to their sexual orientation openness and experiences of family rejection.

The Present Study

This present study aims to compare levels of sexual identity concealment in Jewish LGBTQ+ individuals with LGBTQ+ non-religious individuals (i.e., atheist or agnostic). The authors intended to explore the relationship between general psychological health and concealment in these groups and the relationship between Jewish identity and concealment. This study received ethical approval from The Central University Research Ethics Committee (R81865/RE001).

Methods

Design

An online survey quantitatively explored sexual identity concealment in two groups: a) Jewish LGBTQ+ b) Non-religious LGBTQ+.

Inclusion Criteria

Participants were included if they were living in the UK, aged 18 or over, identified as LGBTQ+, were either Jewish or had no-religious affiliation and able to read/write in English.

Procedures

Prior to their involvement, individuals were provided with information (e.g., about the study, the research team, services to support wellbeing) and required to provide full informed consent. Participants were then asked to complete a brief series of questionnaires via Qualtrics Survey Software.

Recruitment

Recruitment ran between 1.11.2022-22.12.2022. Participants were recruited over social media (e.g., Twitter, Facebook, Instagram), through email circulation with researchers, third sector organisations (i.e., Jewish LGBTQ+ organisations and LGBTQ+ organisations) and correspondence with the British-Jewish community. Participants in the study were asked to forward the web-link on to others to create an internet-based snowball sampling effect.

Measures

Demographics

Participant characteristics were gathered to summarise the groups and exclude those who did not meet criteria. For analyses, participants' sexual orientation was classified into four groups (gay woman, gay man, bisexual and queer and other), gender into three (cis-female, cis-male, and trans or other (TAO)) and education into four (A levels or below, Diploma/Degree, Masters and Doctorate).

Concealment

The Outness Inventory is the gold standard measure in exploring sexual orientation and how often it is discussed (Mohr & Fassinger, 2000). The measure includes 11-items, organised into three subscales: "*Out to Family*" (α=.74), "*Out to World*" (α=.79) and "*Out to Religion*" (α=.97). Participants rated the likelihood that an individual (e.g., mother) or group (e.g., work peers) in question knows about the participant's sexual orientation and how frequently or openly it is talked about. This measure generates an overall score and three subscales, with higher scores reflecting more openness about one's sexual orientation. Only two sub-scale measures[†] (out to world and out to family) were used to explore outness, as "*out to religion*" was deemed misleading for the non-religious group.

Psychological Health

The General Health Questionnaire-12 (GHQ-12, Goldberg, 1972) has good reliability, and validity (Goldberg et al., 1997; Werneke et al., 2000), and has previously been utilised with LGBTQ+ populations to assess mental health symptoms (e.g., Semlyen et al., 2016; Al-Khouja et al., 2019; Urwin et al., 2021).

The GHQ-12 includes 12-items (six positively worded items (e.g., *"Have you been able to concentrate on whatever you are doing?"*) and six negatively worded items (e.g., *"Have you lost much sleep over worry?"*)) measuring general psychological health. For negatively worded items, '*0*' indicates "*Not at all*", '*1*' indicates "*Seldom*", '*2*' indicates "*Usual*" and '*3*' indicates "*More than usual*", while positively worded items are reverse scored. All items are combined to obtain the total score, making the score range 0-36 (with higher scores indicating poorer mental health). Scores over the cut-off point of 12 could be classified as cases (Goldberg et al., 1997).

Additional Questionnaire for the LGBTQ+ Jewish Group:

Jewish Identity

The American Jewish Identity Scales (AJIS) has high reliability, and construct and content validity (Friedlander et al., 2010). The AJIS is the best validated measure for assessing Jewish identity and has been used in various countries outside the UK including Germany, Austria and Israel (Trilesnik et al., 2022). As far as we are aware, the measure has not been used in a UK population.

The AJIS (Friedlander et al., 2010) includes 33-items, organised into two subscales: 15-items on cultural identity (e.g., "*I am proud to be Jewish"*) and 18-items on religious practice (e.g., *"I fast on Yom Kippur"*). Items range from 1-4 on a four-point Likert scale, '*1*' indicated "*Not at all*", '*2*' indicated "*A little*", '*3*' indicated "*Fairly*" and '*4*' indicated "*Very true*". This measure generates an overall score and two subscales, with higher scale scores reflecting greater cultural identity, religious identity and Jewish identification.

Hypotheses

Primary Hypothesis:

1. Sexual orientation concealment[†] will be higher in the LGBTQ+ Jewish group in comparison to the LGBTQ+ non-religious group.

Secondary Hypotheses:

1. Higher concealment[†] will predict poorer mental health across both groups.

2. Higher Jewish identity will predict higher levels of concealment for the LGBTQ+ Jewish group.

Statistical Analysis

Power Analysis for a mixed model analyses of variance (ANOVA) revealed 118 participants were required (with power at .90, alpha at 0.05 and a medium effect size 0.25). Less than 1% of the total data set was missing, with the concealment missing sub-scales prorated to create an overall concealment score.

Meeting Assumptions

Analysis was performed using SPSSv27. Data was examined for potential univariate outliers within each variable (>3 SD from the mean; Tabachnick & Fidell, 1996), with none found. Between-groups comparisons for categorical variables were analysed using Chi-square. Continuous variables were conducted using independent sample t-tests, with normal distribution assessed using boxplots and Shapiro-Wilk test and homogeneity of variance assessed using Levene's statistic. Bonferroni analyses were conducted for significant results.

Differences between Jewish and non-religious groups

Baseline demographic characteristics were explored to assess differences between the Jewish and non-religious groups.

New variables were created for sexual orientation (with bisexual as the reference group) and gender (with cis-female as the reference group).

Primary Hypothesis

A mixed model ANOVA assessed differences both within-group (i.e., comparisons between sub-scales (out to world, out to family)) and between-groups (i.e., Jewish and non-religious), with sphericity assumptions assessed using the Mauchly's test statistic. If assumptions of parametric tests were violated, corresponding nonparametric tests were applied. When patterns of results converged across tests, only results from the parametric tests were reported. A two-tailed alpha level of .05 was used unless stated otherwise.

Secondary Hypotheses

Multiple hierarchical regression analysis was used to assess the secondary hypotheses, with covariates entered into block 1. The new dummy variables (for gender and sexual orientation, with each category being represented as the dichotomous dummy variable; see below), along with the covariate age were entered into the regression equation, with the regression outputs included in the model. The relevant assumptions of this statistical analysis were tested. An examination of correlations revealed that no independent variables were highly correlated (see Appendix H and I), with the collinearity statistics (i.e., Tolerance and VIF) all within accepted limits. An examination of the Mahalanobis distance scores indicated no multivariate outliers. Residual and scatter plots indicated the assumptions of normality, linearity and homoscedasticity were all satisfied (Pallant, 2020).

Dummy Coding

Dummy coding is a way of representing multiple categorical variables, using only zeros and ones (Field, 2009). Field (2009, p254) describes eight steps to using categorical variables as predictors. *"These steps involves: (1) counting the number of groups you want to recode and subtracting one, (2) creating new variables as the value created in the previous step, which are the dummy variables, (3) choosing one group as the baseline reference group (typically the majority group), (4) having chosen the reference group, assign that group values of "0" for all your dummy variables, (5) for the first dummy variable assign the value "1" to the first group you want to compare against the baseline group, assign all other groups "0" for this variable, (6) for the second dummy variable assign the value "1" to the second group you want to compare against the baseline group, assign all other groups "0" for this variable, (7) repeat until you run out of dummy variables, and (8) place all dummy variables into the regression analysis."*

Results

Participant Characteristics

The study recruited 160 participants into an online survey, of whom 70 were Jewish LGBTQ+ and 81 non-religious LGBTQ+ (See Table 8 for baseline characteristics). Nine participants were ineligible and screened out prior to completing the questionnaires.

Over half the participants were cis-female (55.6%) and approximately a fifth cis-male (22.5%). Participants identified as predominantly White British (54.3%) or Jewish (25.8%). Many participants identified as bisexual (35.76%). The LGBTQ+ non-religious participants were on average younger and included more bisexual and pansexual individuals, albeit had similar education backgrounds to the Jewish LGBTQ+ group. Participants' Jewish identity ranged across denominations with the highest proportion identifying as culturally Jewish (24.3%), with a small proportion from the Orthodox and Hasidic communities (8.6%).

Sexual orientation was not statistically significantly different between Jewish and non-religious groups, $\chi^2(3) = 2.96$, $p>.05$, neither was **education** $\chi^2(3) = 6.40$, $p> .05$. However, the distribution of **gender** types was significantly different between Jewish and non-religious groups, $\chi^2(2) = 6.97$, $p = .031$. There were significantly more cis-females in the non-religious group. There was also a significant difference in **age** between Jewish and non-religious groups, with Jewish participants significantly older than non-religious, M= 4.17, SE= 1.45, $t(99.69) = 2.87$, p=.003. Therefore, gender and age were controlled in further analyses.

Table 8. A summary of the descriptive characteristics of participants

Variables of Interest	Overall† *N* = 151 (%)	LGBTQ+ Jews *N* = 70 (%)	LGBTQ+ non-religious *N* = 81 (%)
Gender			
Cis-male (male gender identity same as birth)	34 (22.5)	22 (31.4)	12 (14.8)
Cis-female (female gender identity same as birth)	84 (55.6)	32 (45.7)	52 (64.2)
Transgender man	3 (2.0)	3 (4.3)	0 (0)
Transgender woman	2 (1.3)	1 (1.4)	1 (1.2)
Gender non-conforming, gender nonbinary, or gender queer	24 (15.9)	9 (12.9)	15 (18.5)
Other (e.g., agender)	2 (1.3)	1 (1.4)	1 (1.2)
Prefer not to answer	2 (1.3)	2 (2.8)	0 (0)
Age			
Mean (SD)	29.12 (9.2)	31.19 (10.97)	27.01 (5.65)
Range (years)	18-69	18-69	18-45
Race/Ethnicity			
Indian	1 (0.7)	0 (0)	1 (1.2)
Chinese	3 (2.0)	0 (0)	6 (3.7)
Black, African, Caribbean, or Black British	1 (0.7)	0 (0)	1 (1.2)
White English, Welsh, Scottish, Northern Irish or British	82 (53.6)	19 (27.1)	63 (77.8)
Irish	1 (0.7)	1 (1.4)	0 (0)
Any other White background	14 (9.3)	7 (10.0)	7 (8.6)
Mixed or Multiple ethnic groups	3 (2.0)	3 (4.3)	0 (0)
White and Asian	5 (3.3)	0 (0)	5 (6.2)

Other ethnic group (e.g., Latinx)	1 (0.7)	1 (1.4)	0 (0)
Jewish	39 (25.8)	39 (55.7)	0 (0)
Prefer not to answer	1 (0.7)	0 (0)	1 (1.2)
Highest Level of Education			
Secondary (up to GCSEs / equivalent)	1 (0.7)	0 (0)	1 (1.2)
GCSEs / equivalent	2 (1.3)	1 (1.4)	1 (1.2)
A levels / equivalent	18 (11.9)	6 (8.6)	12 (14.8)
Diploma / Degree	59 (39.1)	33 (47.1)	26 (32.1)
Masters	49 (32.5)	24 (34.3)	25 (30.9)
Doctorate / PhD	21 (13.9)	6 (8.6)	15 (18.5)
Prefer not to answer	1 (0.7)	0 (0)	1 (1.2)
Sexual Orientation			
Lesbian/ gay woman	31 (20.5)	16 (22.9)	15 (18.5)
Gay man	24 (15.9)	14 (20)	10 (12.3)
Bisexual	54 (35.8)	21 (30)	33 (40.7)
Pansexual	15 (9.9)	4 (5.7)	11 (13.6)
Queer	19 (12.6)	12 (17.1)	7 (8.6)
Asexual	5 (3.3)	0 (0)	5 (6.2)
Other (Demisexual, multiple labels)	3 (2.0)	3 (4.3)	0 (0)
Religious Orientation			
Jewish, Reform	13 (8.6)	13 (18.6)	
Jewish, Conservative / Masorti	15 (9.9)	15 (21.4)	
Jewish, Orthodox	5 (3.3)	5 (7.1)	
Jewish, Modern Orthodox / centralist Orthodox	10 (6.6)	10 (14.3)	
Jewish, Hasidic	1 (0.7)	1 (1.4)	
Jewish, Humanistic / non-affiliated (Jewish by culture, without reference to G_d)	17 (11.3)	17 (24.3)	
Other Jewish denomination (e.g., Sephardi, liberal)	9 (6.0)	9 (12.9)	
No religion (including atheist, agnostic)	80 (53.0)		80 (98.8)
Prefer not to answer	1 (0.7)		1 (1.2)

Note. † This does not include ineligible participants (N = 9).

Table 9. Participants' mean scores across variables of interest

Variables of Interest	Total N = 151	LGBTQ+ Jews N = 70	LGBTQ+ Non-religious N = 81	Independent Samples T-tests	Effect size (d)
Psychological Health					
Total Score (M, SD)	17.72 (2.82)	18.29 (2.99)	17.23 (2.59)	t(149) = 2.32, p=.022*	.38
Concealment (M, SD)					
Family	4.10 (1.89)	4.56 (1.69)	3.70 (1.97)	t(148.99) = 2.91, p=.004*	.47
World	3.49 (1.74) †	4.00 (1.76) †	3.06 (1.61)	t(148) = 3.40, p<.001**	.56
Religion	1.39 (2.10) †	2.80 (2.31)	.12 (.48) †	t(74.47) = 9.53, p<.001**	1.65
Overall	3.48 (1.38)	4.10 (1.36)	2.94 (1.17)	t(149) = 5.65, p<.001**	.92
Identity (M, SD)					
Overall		2.30 (.61)			
Religious		2.05 (.69)			
Cultural		2.60 (.63)			

Note. † Represents different sample sizes for these subscales: Total world concealment n=150; Queer Jewish world concealment n=69; Total religion concealment n=148; Queen non-religious religion concealment n=78.

* Significant effect p>.05

** Significant effect p>.001

Primary Hypotheses

Sexual orientation concealment† will be higher in the LGBTQ+ Jewish group in comparison to the LGBTQ+ (non-religious) group.

Significant mean differences between Jewish and non-religious groups were found in psychological health, concealment subscales and overall concealment (see Table 9). As predicted, there was a significant main effect of concealment, $F(1, 148) = 13.84$, $p<.001$, $\eta_p^2=.086$, indicating participants were more open about their sexual orientation to family than to the world (see Figure 6). Contrary to predictions, there was a significant main effect of group, $F(1, 148) = 15.55$, $p<.001$, $\eta_p^2=.095$, indicating LGBTQ+ Jewish participants were more open about their sexual orientation than non-religious participants (see Figure 6). There was no significant interaction between concealment and group $F(1,148) = .027$, p>.05.

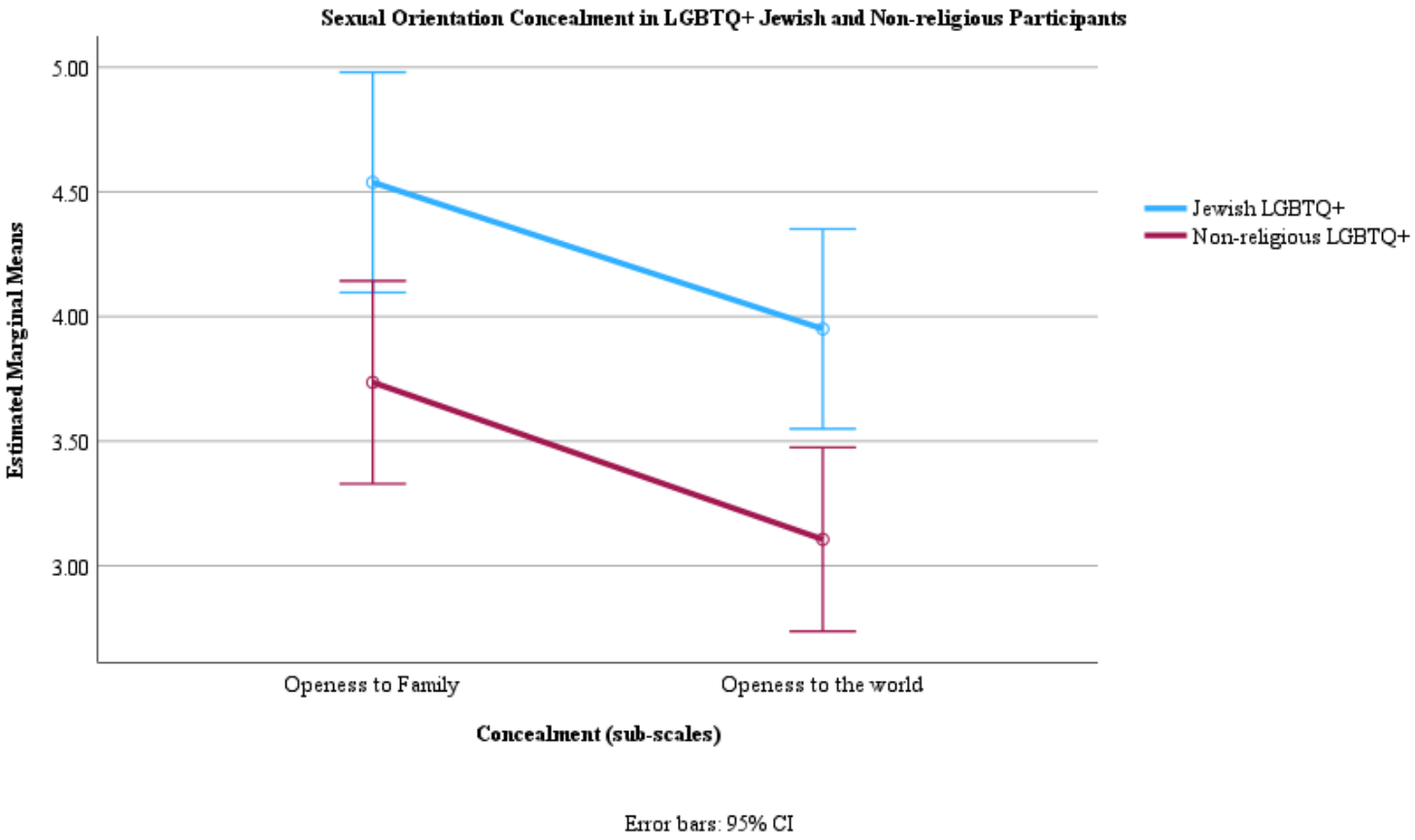


Figure 6. Sexual orientation concealment in LGBTQ+ Jewish and LGBTQ+ non-religious participants

Note. The higher means suggests more openness about sexual orientation status, whilst lower means represent more concealment.

Secondary Hypotheses

Higher concealment will predict poorer mental health across both groups.

To find potential covariates across the sample, baseline characteristics were correlated with concealment (see Appendix H). A two-stage hierarchical multiple regression was conducted with covariates entered into block 1; and concealment (two sub-scales: family, the world) entered in block 2. Stage one of the regression, R^2= .07, F(6, 143)= 1.80, p=.10 did not predict poorer mental health. After taking into account confounding variables, concealment (to the world and to family) did not significantly predict poorer mental health, R^2= .087, F(8, 141) = 1.69, p=.11.

Higher Jewish identity will predict concealment for the LGBTQ+ Jewish group.

To find potential covariates, baseline characteristics for the Jewish LGBTQ+ group were correlated with concealment (see Appendix I). Three separate two-stage

hierarchical multiple regressions were conducted with covariates entered into block 1; and Jewish identity (two sub-scales: religious and cultural) entered in block 2.

Concealment to Family Sub-scale. Stage one of the regression, $F(6,63)=3.01$, $p=.012$, $R^2=.22$ significantly predicted concealment to family. After taking into account confounding variables, Jewish identity statistically significantly predicted concealment to family, $F(8,61)=2.38$, $p=.027$, $R^2=.24$. Sexual orientation was a significant predictor of less concealment to family for lesbians, b=-.29, $t(70) = 2.00$, $p=.05$ and gay men b=-.46, $t(70)=2.66$, $p<.01$, when compared to bisexuals. The other variables did not significantly predict concealment to family. ***Concealment to the World Sub-scale.*** Stage one of the regression, $F(6,62)=3.41$, $p=.006$, $R^2=.25$, significantly predicted concealment to the world. After taking into account confounding variables, Jewish identity statistically significantly predicted concealment to the world, $F(8,60) = 2.83$, $p=.01$, $R^2= .27$. Sexual orientation was a significant predictor of less concealment to the world for gay men b=-.52, $t(70) = 3.10$, $p=.003$, when compared to bisexuals. The other variables did not significantly predict concealment. ***Concealment Scale.*** Stage one of the regression, $F(6,63)=4.42$, $p=.001$, $R^2= .30$, significantly predicted overall concealment. After taking into account confounding variables, Jewish identity statistically significantly predicted overall concealment, $F(8,61)=3.27$, $p=.004$, $R^2= .30$. Sexual orientation was a significant predictor of less overall concealment for lesbians, b=-.33, $t(70) = 2.36$, $p=.021$ and gay men b=-.62, $t(70) = 3.77$, $p<.001$, when compared to bisexuals. The other variables did not significantly predict concealment.

Discussion

The key findings of the study have been summarised. LGBTQ+ participants were significantly more open about their sexual orientation to their family than the world. Contrary to our prediction, Jewish LGBTQ+ participants were significantly more open about their sexual orientation (to both their family and the world) compared to non-religious LGBTQ+ participants. Again, contrary to our prediction, the study did not find more concealment predicted poorer mental health. Although, the Jewish LGBTQ+ group had significantly poorer mental health compared to non-religious LGBTQ+ participants, with a small-medium effect size. Furthermore, Jewish LGBTQ+ individuals who rated higher on the Jewish identity scale (cultural and

religious) were more likely to conceal their sexual orientation to family and the world, although this was not significantly related to poorer mental health. These findings contradict the minority stress theory and would suggest that the theoretical basis are inaccurate. The minority stress process of concealment may be more complex for LGBTQ+ individuals as to what Meyer's model accounts for in contributing to poor mental health outcomes. The findings from the current study would argue other processes may be more important in contributing to mental health outcomes, and that the role of concealment may be more sophisticated. The authors would argue that the minority stress model needs updating to account for how concealment may interact but not predict poorer mental health.

Differences in Concealment

Concealment to both family and the world was significantly higher in the non-religious LGBTQ+ group, when compared to the Jewish LGBTQ+ group. The importance of Jewish cultural and family values over religious practice for this sample may explain their openness about their sexual orientation. It should be noted that the non-religious group mean score in relation to openness to family or the world was on average one point lower than the Jewish group; whereby differing between statements of *"the person probably knows about your sexual orientation status, but it is* ***never*** *talked about"*, in comparison to *"the person probably knows about your sexual orientation status, but it is* ***rarely*** *talked about"*. Therefore, although there was more openness in the Jewish group, concealment was still present. Jewish families may know about the sexual orientation and be accepting, but certain topics (e.g., conversations about romantic partners) may be avoided or silenced as a coping strategy, as Meyer (2003) suggested. This may not predict but contribute to poorer wellbeing and internalised mental health problems (Altman & Royston, 2006; Pachankis et al., 2020).

Concealment and Mental Health

The finding that concealment did not predict poorer mental health conflicts with our hypothesis and prior research (Meyer, 2003; Chae & Ayala, 2009; McCann et al., 2020; Pachankis et al., 2020). The authors consider various explanations to this outcome. Concealment may be a coping strategy that protects individuals and families, for example from family conflict and associated stigma, with family

cohesion regarded as a better alternative than being open about one's sexual orientation. Although, exploring the longitudinal impact on mental health and access to coping strategies (i.e., social support, romantic partner, substances) would be important to consider. Concealment not predicting poorer mental health may be a result of ongoing shifts within UK culture with non-heteronormative identity becoming increasingly more visible and widely accepted in secular society (Pew Research Centre, 2020). LGBTQ+ people reported feeling more confident when they saw and identified with others who had shared characteristics (Major & O'Brien, 2005), with identity affirmation unrelated to depression but positively associated with outness (Paul et al., 2014). LGBTQ+ people also reported a greater sense of empowerment and control (Corrigan et al., 2010; Switchboard, 2019) when choosing when to "*come out*", resulting in reduced stigma and mental health problems (Corrigan, 2022).

The trainee acknowledges that other minority stress processes included in Meyer's model may better predict mental health for this population (see Figure 5). As the literature suggests, this may be due to proximal stressors, such as expectations of family rejection (Fox et al., 2019; Abu-Ras et al., 2021) and internalised homophobia (Shilo & Savaya, 2012), which have been associated with negative mental health outcomes for LGBTQ+ people of faith. Therefore, future research may explore how other proximal stressors better predict mental health within the Jewish LGBTQ+ population.

Poorer Mental Health in Jewish LGBTQ+

The sample of Jewish participants had poorer mental health when compared to the non-religious LGBTQ+ group. Elevated levels of psychological distress in the Jewish group may be explained by LGBTQ+ minority stress processes (e.g., expectations of rejection, internalised homophobia, see Figure 5) or faith related negative stressors, e.g., experiences of antisemitism, intergenerational trauma, access to social support (Reisen et al., 2001; Kulick et al., 2017). Future research may wish to qualitatively explore the experiences of LGBTQ+ Jewish people that contribute towards mental health difficulties and understand how services can meet this need.

Concealment and Jewish Identity

Higher levels of Jewish identity significantly predicted concealment of sexual orientation. This may be a result of the Jewish sample being from a predominantly secular Jewish background and of a young age. Younger liberal and reform Jews in the UK may be more open about their sexual orientation, when compared to Orthodox Jews. This finding compliments the literature that religious gay and bisexual Jews in Israel were more likely to conceal their sexual orientation from family and close friends (Shilo et al., 2016), in comparison to Jewish secular sexual minorities (Shilo & Mor, 2014; Shilo & Savaya, 2012). This may be due to heightened identity conflict (Shilo et al., 2016), fears of isolation, family and community rejection (Switchboard, 2019; Fox et al., 2019; Abu-Ras et al., 2021) and negative social consequences (Shilo & Savaya, 2012; Pachankis & Bränström, 2018; Etengoff & Rodriguez, 2021). However, this was not significantly correlated to mental distress. People who identify as more culturally and religiously Jewish may foster resilience to psychological distress (Harari et al., 2014). Meyer's model (2003, see Figure 5) shows how social support from individuals and/or the community may result in positive mental health outcomes.

Strengths and Limitations

The strengths of this study included: (1) recruiting the largest sample of LGBTQ+ Jews in a quantitative study to date; (2) addressing the religious and cultural identity factors related to concealment and LGBTQ+ Jews' mental health; and (3) working collaboratively with Jewish LGBTQ+ people, organisations and LGBTQ+ organisations in the UK to create a meaningful research study. Although this study was limited to UK-Jews, these findings may be replicable and valid in other religious groups.

The study had certain limitations. The overall sample included a high proportion of people who identified as educated, female, bisexual and White. The sample only included a small proportion of Orthodox Jews, which may be due to access to the questionnaire (e.g., internet access) or not wanting others to know their sexual orientation, therefore this study may have validity limitations to certain Jewish denominations. It is important to account for sample bias; the authors note that people who make up the minorities within the study may have different experiences of

concealment. For example, higher levels of education have been associated with better mental health outcomes over time, with protective effects higher in women and rural residents (Kondirolli & Sunder, 2022). For Jewish LGBTQ+ people in the UK, most social activities related to sexual orientation and religion are situated in London. This study did not collect information that could explore the impact of geographical location on concealment and wellbeing. The nonprobability sampling likely overrepresents the experience of sexual minorities who are open about their sexual orientation, compared with those who are not open. Furthermore, the study only looked at concealment and other processes included in Meyer's model may better explain and predict mental health outcomes in this population.

Future Research Recommendations

The need for culturally sensitive and intersectional research and clinical work with LGBTQ+ populations is evident. The current findings contradict Meyer's (2005) minority stress theory (see Figure 5) and would suggest that the theoretical basis is inaccurate. Future research should consider exploring other factors that impact both concealment and mental health, such as faith related negative stressors (e.g., discrimination, internalised homophobia, expectation of rejection). Investigating and updating processes within minority stress model that may result in poorer mental health would be important to explore within a LGBTQ+ people of faith population.

Future research could look to qualitatively explore the other reasons why people conceal their identity and understand the implications on ethno-religious LGBTQ+ Jewish people and other people of faith. There may be cultural differences between Western LGBTQ+ people who experience acceptance or rejection, when compared to people from religious or ethnically diverse cultures and identify as LGBTQ+, whereby they are accepted, but certain topics of conversation are avoided or silenced.

Clinical Implications

The results suggest that conversations between LGBTQ+ Jewish people and their family or others around sexual orientation concealment are that *"the person probably knows about your sexual orientation status, but it is* ***rarely*** *talked about."* Both NHS services and LGBTQ+ organisations could support, and model ways to avoid silencing conversations, that may be more common with heteronormative individuals.

For example, the "*Time To Talk*" campaign (MIND, 2023), using social media and videos to demonstrate the importance of engaging in conversation to reduce stigma and discrimination.

Services may require cultural training to understand the differences in denominations across Judaism, and how Jewish identity may predict more concealment. Increased understanding may help staff's awareness of how Jewish and other people of faith may identify with their ethno-religious identity.

At this stage, implications for services may include not assuming concealment results in poorer mental health for LGBTQ+ people. Future research exploring what contributes towards mental health difficulties for LGBTQ+ Jews may help to establish ways services can meet the needs of this population, and support LGBTQ+ people across different faiths.

Conclusions

The current study advances the research on LGBTQ+ people of faith in a number of significant ways and represents one of the first analyses of LGBTQ+ UK-Jews' mental health experiences. In addition, this study adds to the literature, identifying that non-religious LGBTQ+ people concealed significantly more than LGBTQ+ Jewish participants to their family and the world. In contrast to recognised theories of Minority Stress, concealment was not a predictor of poorer mental health, although this may be explained by other processes in Meyer's (2003) minority stress model (e.g., internalised homophobia, expectation of rejection). LGBTQ+ Jews reported poorer mental health than the non-religious group. There is a need for additional research to explore concealment and understand it's impact and purpose for LGBTQ+ Jewish people, as well as the experiences of LGBTQ+ Jewish people that contribute towards mental health difficulties. This may help to improve access to mental health support for an ethno-religious Jewish LGBTQ+ population, and support how services can meet their needs as well as LGBTQ+ people across all faiths.

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Executive Summary for Theoretically Driven Research

Why the study was conducted.

People from Lesbian, Gay, Bisexual, Transgender, Queer, plus individuals from other minority sexual groups (LGBTQ+) may experience harassment, discrimination and distress due to their sexual orientation. According to Minority Stress Theory (Meyer, 199; 2003), people from minority groups (e.g., religion, sexuality) can experience excess stress, which may contribute towards mental distress. This may be particularly difficult for LGBTQ+ people of faith when their religion opposes same-sex relationships. LGBTQ+ people living in more stigmatising environments may therefore choose to conceal their sexual orientation and this can negatively impact their mental health and wellbeing.

British-Jews are considered an ethno-religious group, representing the fifth largest Jewish community in the world and 0.5% of the UK population (Graham & Boyd, 2022). Denominations exist within the Jewish community regarding a person's Jewish identity, their religious philosophy, affiliation and cultural practice. Research has shown that religion can act as a protective factor for mental health difficulties (Graham & Boyd, 2022). However other research has shown that at times the combination of religious and LGBTQ+ identity can cause distress, for example, Jewish Orthodox gay and bisexual men in Israel experienced mental distress, identity conflict, and concealed their identity from family and close friends (Shilo et al., 2016). In some religious groups, concealment of sexuality was associated with poorer mental health and wellbeing, fears of isolation, family rejection and negative social consequences (Fox et al., 2019; McCann et al., 2020; Abu-Ras et al., 2021; Etengoff & Rodriguez, 2021). LGBTQ+ people of faith may experience additional and cumulative stressors, therefore understanding their experiences may help to develop targeted support.

The aims of the study

This study looked to explore differences in concealment of sexual orientation between LGBTQ+ people of a Jewish faith compared to non-religious LGBTQ+ people. The study explored:

- The differences in concealment between the Jewish and non-religious group.

- The relationship between general psychological health and concealment.
- The relationship between Jewish identity and concealment.

What the study involved

Participants were recruited over social media and via third sector organisations. Inclusion criteria were:

- Living in the UK.
- Age 18 years or over.
- Identified as LGBTQ+.
- Identified as either Jewish or no religious affiliation.
- Able to read/write in English.

Participants answered questions about their demographics, concealment, general psychological health and Jewish participants answered additional questions about their Jewish cultural and religious identity.

What the study found

160 people took part in the study, of whom 70 Jewish and 81 non-religious were eligible. The sample predominantly identified as cis-female (55.6%), bisexual (35.8%) and White British (54.3%) or Jewish (25.8%). Participants' Jewish identity ranged across denominations, with a small proportion from the Orthodox and Hasidic communities (8.6%). The study found:

- Non-religious LGBTQ+ participants concealed their sexual orientation more than Jewish participants.
- Concealment of one's sexual orientation did not predict poorer mental health, though Jewish participants had significantly poorer mental health than the non-religious group.
- People who identified as more culturally and religiously Jewish concealed more than other Jewish participants.

Conclusions

The importance of Jewish cultural and family values over religious practice may explain their openness about their sexual orientation, when compared to the non-

religious group. The finding that concealment did not predict poorer mental health conflicts with prior research (Meyer, 2003; McCann et al., 2020). This may be a result of ongoing shifts within UK culture with non-heteronormative identity becoming increasingly more visible and widely accepted in secular society (Pew Research Centre, 2020). Although concealment did not predict poor mental health, as Minority Stress Theory suggests, poorer mental health in the Jewish group may be explained by other factors, such as expectations of family rejection (Fox et al., 2019; Abu-Ras et al., 2021) and internalised homophobia (Shilo & Savaya, 2012), which have been associated with negative mental health outcomes for LGBTQ+ people of faith. Future research should explore how other stressors predict mental health within the Jewish LGBTQ+ population, and across other faiths. As expected, higher levels of Jewish identity significantly predicted concealment. Future research should look to qualitatively explore concealment and the impact and purpose for LGBTQ+ Jewish people, and people across other faiths. Further research in this area would facilitate services to better meet individuals' needs and to understand the experiences that contribute towards mental health difficulties for LGBTQ+ Jewish people and LGBTQ+ people across all faiths.

Connecting Reflective Narrative

Identifying as a Jewish Modern-Orthodox woman is an important part of my identity. When deciding on what I wanted to explore in research as part of DClinPsych training, I felt I had a responsibility and an opportunity to research topics that I was both interested in and had personal meaning to me.

Upon entering training, I was fortunate to have worked with people who have experiences of psychosis. This involved working on randomised control trials for people with an At-Risk Mental State (ARMS) of psychosis, First Episode Psychosis and more long-term conditions. During my first PhD, I explored expressed emotion in the ARMS and the impact on family members and carers. I was keen to continue research with this population in promoting treatment choice, equal access to services and normalising mental health difficulties. I continue to hold the value of supporting multiple members of a system and the importance of working with families and carers to result in long-lasting change and positively impact the wellbeing of a whole system.

During training I have stood by my values, such as increasing access for people experiencing mental distress from diverse and minority groups. The three research projects that I have embarked upon hold similar themes around diversity, access to services and vulnerabilities impacting on one's mental health. I have learnt a lot on the journey of completing this thesis and have reflected on the intensity of the process.

Critical Review of the Literature

My initial idea was published in April 2020. I returned to my prior research interest of psychosis and sought my supervisor's opinion on exploring the psychosocial needs of siblings of people with experiences of psychosis. Clinical experience and my publication from my first PhD highlighted the impact on siblings of people with an ARMS. I was curious how this may look across the psychosis umbrella and across cultures. Disruption to relationships for siblings during adolescence/early adulthood can have significant implications, specifically to personality development, identity formation and social support. When scoping the literature, the previous systematic

review only included Western studies. On reflection, I felt saddened that the findings and comparisons across constructs and studies failed to account for differences in cultures. My interest in understanding the experiences of diverse cultures helped to foster a study that would adhere to clinical utility and theoretical grounding for this project.

In comparison to my other projects, this felt the most methodical and meticulous in nature. Research supervision was particularly helpful in thinking through rationale for specifics within the project. These decisions were documented and deemed important when considering implications for the treatment for the families, and in supporting the siblings themselves, particularly younger siblings. For example, having multiple perspectives from different cultures, psychosis diagnoses and personal perspectives was thought to create a breadth of knowledge about the challenges and help to guide services how best to support siblings.

Service Improvement Project

The development of this project came during my first-year placement in an Older Persons service. During supervision, my supervisor and I discussed the clinical support provided to older persons with experiences of hallucinations and how this differed across conditions. My external supervisor encouraged me to explore potential barriers within the service for older persons who were experiencing distressing hallucinations. It was helpful that the aims of the study were in line with the Community Mental Health Team transformation agenda, service innovation and supported by senior management.

The project enabled me to develop my research skills of grounding theory through the Plan-Do-Study-Act improvement strategy and to identify service development recommendations. The experience was enjoyable and allowed me to reflect on the specific service development questions and training. From the findings, I learnt about the importance of understanding service context, restraints, and the value of having senior management on board when implementing training and change.

Theoretically Driven Project

Growing up, Judaism was modelled to me through an Orthodox lens. For example, men and women sat separately in the Synagogue, services were in Hebrew and the Rabbi identified as male. I was not taught about same-sex relationships in neither school nor religious education, other than it was regarded as wrong and shameful. When I look back on my childhood and think of role-models, I was not aware of any LGBTQ+ persons. During late adolescence, I met Jewish people who openly identified as LGBTQ+. I started to listen to them speak about their LGBTQ+ identity, their experiences concealing their identity, family rejection/acceptance and the impact on their mental health. Looking towards the beginning of my training in 2020, this coincided with the campaign to ban conversion therapy and calls for the UK Government to commit to a full legislative ban. On reflection, my research project felt timely, to understand the experiences of a minoritised group. On a more personal level, I wanted to support my friends, family and LGBTQ+ members within the Jewish community by furthering my understanding around mental health to better support their needs. I am proud to be Jewish and want to support other people from minority groups, who may experience additional stressors that negatively impact their mental health.

When reflecting across the three projects, this was the most challenging, yet the most rewarding. I overcame multiple challenges, from obtaining an internal and external supervisor who would support this project, to presenting this project on two occasions to the university. The development of this project was time consuming, for example meetings with key stakeholders within the LGBTQ+ Jewish community and awaiting ethical approval. Retaining constant enthusiasm and belief for this project was exhausting, however my motivation was maintained by small accomplishments (e.g., achieving recruitment target within five weeks) and my values and feelings of responsibility towards this project. My learning from this project has been firstly, how to link clinically relevant questions with a theoretical understanding to aid the development of the literature, secondly the importance and value of co-production and co-development, and thirdly, reflecting on one's own position when involved in research, academia and clinical work.

Acknowledgments

I am grateful to everyone who participated in my research. I hope that this research will contribute towards enhancing service user treatment choice, reduce stigma and result in better outcomes for individuals and their families and carers.

I am grateful to all my research supervisors for their support, guidance and encouragement throughout the three years. I would particularly like to thank Dr Fiona McFarlane, whose kindness and patience has been invaluable in helping me keep going and supporting me to research a topic of great importance to me.

I would like to say thank you to my wonderful cohort and fellow trainees. Sharing this process with a group of inspiring, resilient and passionate trainees has been a privilege. A special thank you to Ellie, for your generosity with parking permits and endless encouragement and compassion throughout training.

I would like to thank my friends and family for putting up with me over the past three years. Thank you, Sarah, for your advice and wisdom when deciding to start another PhD. To my parents, Laureen and Richard, and my brother, Stuart, thank you for your love, sacrifice and for listening to me talk about these projects for many hours. Finally, my husband, Dan, I will be forever grateful to you in supporting and believing in me. Thank you for filling my life with laughter, love and ice-cream.

Appendices

Appendix A. Author guidelines for submission: critical review of literature

Clinical Psychology & Psychotherapy.

Sections
1. Submission
2. Manuscript Categories and Requirements
3. Preparing The Submission
4. Editorial Policies and Ethical Considerations
5. Author Licensing
6. Publication Process After Acceptance
7. Post Publication
8. 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 meeting or symposium.
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New submissions should be made via the **Research Exchange** submission portal **https://submission.wiley.com/journal/CPP**. Should a manuscript proceed to the revision stage, authors will be directed to make revisions via the same submission portal. Authors may check the status of 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**.

For help with submissions, please contact the Editorial Office at **CPPedoffice@wiley.com**

Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid

research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.
This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.
Submissions which fall outside of Aims and Scope, are not clinically relevant and/or are based on studies of student populations will not be considered for publication and will be returned to the author.

Free Format submission
CPP now offers Free Format submission for a simplified and streamlined submission process.
Before you submit, you will need:

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- The title page of the manuscript, including:
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    - Statements relating to our ethics and integrity policies, which may include any of the following (Why are these important? We need to uphold rigorous ethical standards for the research we consider for publication):
        - data availability statement
        - funding statement
        - conflict of interest disclosure
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        - clinical trial registration [OPTIONAL TEXT, if the journal has a double-blind peer review policy: Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and supply a separate title page file.]

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2. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research Article: Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).
Comprehensive Review: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).
Measures Article: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).
Clinical Report: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

3. PREPARING THE SUBMISSION

Parts of the Manuscript
The manuscript should be submitted in separate files: main text file; figures.
File types
Submissions via the new Research Exchange portal 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) formats.
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."
Cover Letters and Conflict of Interest statements may be provided as separate files, included in the manuscript, or provided as free text in the submission system. A statement of funding (including grant numbers, if applicable) should be included in the "Acknowledgements" section of your manuscript.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
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3. The full names of the authors;

4. The authors' complete institutional affiliations where the work was conducted (Institution Name, Country, Department Name, Institution City, and Post Code), with a footnote for an author's present address if different from where the work was conducted;
5. Conflict of Interest statement;
6. Acknowledgments;
7. Data Availability Statement
8. Abstract, Key Practitioner Message and 5-6 keywords;
9. Main text;
10. References;
11. Tables (each table complete with title and footnotes);
12. Figure legends;

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Please refer to the journal's **Authorship** policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

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, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

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Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the **Conflict of Interest** section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

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Keywords

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2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

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For more information about APA referencing style, please refer to the **APA FAQ**. Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486. doi: **10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from *http://www.youtube.com/watch?v=Vja83KLQXZs*

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Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

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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.

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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.

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.

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Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

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The following points provide general advice on formatting and style.

1. **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.
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3. **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
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The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. **If the authors have no conflict of interest to declare, they must also state this at submission**. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

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The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

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2. Been involved in drafting the manuscript or revising it critically for important intellectual content;
3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
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7. POST PUBLICATION

Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).
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- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- The corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

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Email: **CPPedoffice@wiley.com**

Author Guidelines updated 17th November 2020

Appendix B. Author guidelines for submission: service improvement project

Nursing Older People.

Research articles

These author guidelines will help you submit a research article for publication in the 'evidence & practice' section of RCNi journals. Separate guidelines are available for general clinical articles, continuing professional development (CPD) articles, CPD modules, 'How to' modules and the journal Nurse Researcher. For further information on publishing with RCNi go to **rcni.com/write-us**

Please note that your article must be submitted to one journal ONLY, whether published by RCNi or any other company. Submission to more than one journal will not increase your chances of publication. Editors will not consider articles that have been submitted or published elsewhere

Purpose

The main purpose of the 'evidence & practice' section of RCNi journals is to support nurses to improve patient care through evidence-based nursing. Research articles published in RCNi journals report and discuss the findings of studies that have relevance and implications for nursing practice. The studies must have been conducted within the previous five years.

For an overview of RCNi's journals go to **rcni.com/write-us/explore-our-journals**

Peer review

Research articles submitted for publication in the 'evidence & practice' section of RCNi journals are peer reviewed. Most RCNi journals use double-blind peer review.

Length

Research articles must be between 3,000 and 5,400 words including the abstract, body text, any boxes, tables and figures, and references. Articles exceeding the word count will be returned to authors for cutting before peer review.

Abstract

An abstract of between 80 and 150 words is required. The abstract should be structured using the following subheadings: Background, Aim, Method, Findings (or Results), Conclusion. It must not contain reference citations nor any information that is not in the article itself.

Structure

A research article should be structured as described below.

Background

The 'Background' section sets the context for the study and explains its rationale if needed. Some studies may include a literature review, in which case the 'Background' section can be followed by a 'Literature review' section.

The 'Literature review' section provides a critical analysis of published work, especially research, in your chosen area of study. It should encompass the most recent and relevant publications in your chosen area as well as any seminal work; identify any gaps in the literature; and outline the importance and relevance of your study.

Author guidelines RCNi

If you are writing an article to report and discuss the findings of a literature review, please follow the 'general clinical articles' author guidelines, available at **rcni.com/write-us-general-guidelines**

Aim

The aim of the study should be clearly stated here. The aim can usually be summarised in one sentence, unless there are additional objectives that need to be stated.

Method

The 'Method' section should state when the study was conducted and describe the methods used, including:

- Design and setting – What was the study design? Did you use a quantitative or qualitative approach? In what setting(s) did the study take place? What month(s) and year(s) was the study undertaken in?
- Research question – What was the research question (if relevant)? What method was used to formulate it (for example, the PICO or PEO tool)?
- Participants or respondents – Who were they? How were they selected? The required sample size and rationale for it, characteristics of participants or respondents that could have influenced the findings or results, risk of bias and sample representativeness should be discussed.
- Data collection – How were data collected? What data collection tool was used? Had it been shown in previous studies to be valid and reliable? Did you conduct a pilot study to test its validity and reliability?
- Data analysis – What was the method of data analysis? What was the rationale for using that method?
- Ethical considerations – Any research requires ethical approval. How ethical approval was obtained and from whom should be stated at the end of the 'Method' section under a separate subheading. This subsection should also explain how participants' or respondents' consent was gained and how their confidentiality was protected.

Findings (or Results)

If the research was qualitative, this section should be entitled 'Findings'. If the findings originate from a thematic analysis of the data, the section can be structured according to the themes that emerged. If the findings originate from focus groups or interviews, the text can be supported by verbatim quotes.

The quotes should be attributed to participants designated by role and number – for example, Nurse 1, Nurse 2, Nurse 3 or Patient 1, Patient 2, Patient 3 and so on. Interpretation of the quotes is encouraged and any unexpected or unusual findings should be acknowledged.

If the research was quantitative, this section should be entitled 'Results'. Results should be reported in detail and the text should be supported by boxes, tables and/or figures to simplify and give meaning to the data. Quantitative data must be given in numbers and percentages in the text, boxes, tables and figures, and must be checked before submission to ensure they are complete, accurate and consistent.

If the research used a mix of quantitative and qualitative methods, this section should be entitled 'Findings'.

Discussion
In this section, the findings or results are discussed in relation to the study aim, other research findings and relevant policies and clinical guidelines. You should attempt to explain any discrepancies between your findings or results and those of others. You should also explain the significance of your study findings or results. The 'Discussion' section gives you an opportunity to make recommendations – for example for policy, education and/or research. What do you feel should happen on the basis of the findings or results?

Research articles must have a separate 'Limitations' subsection, placed at the end of the 'Discussion' section, where you discuss any challenges encountered while conducting the study, issues affecting the reliability or generalisability of the findings or results, and whether and how the method could have been strengthened.

Conclusion
The main points of the article and overall findings or results of the study should be summarised in a 'Conclusion' section, which should also provide a clear answer to the study aim and/or research question.

Implications for practice
Research articles must have between three and six implications of the study and its findings or results for nursing practice, presented in bullet points after the conclusion under a separate subheading.

Style and tone
When writing your research article, you should keep readers in mind, in particular their professional level and experience, and where appropriate the specialty in which they work. The article should have a consistent and user-friendly tone. The style should be professional but straightforward and does not need to be overly academic.

You should aim to make the article factual, clear, concise and evidence based. The information you provide must be accessible, accurate and unambiguous. Think about the best way to present the information: it may be more clearly understood as a list of bullet points, box, table or figure.

The use of jargon and abbreviations should be avoided. Acronyms should be written in full at first mention and, if used again, abbreviated thereafter. For example: Nursing and Midwifery Council (NMC) at first mention, NMC thereafter. Articles that refer to policy or legislation must state the country to which it applies.

Boxes, tables and figures
Boxes, tables and figures must be numbered, captioned and cited in the article in their order of appearance. They should be easy to read and uncluttered. All symbols and abbreviations should be explained. Sources should be indicated and included in the references. Figures may include graphs, bar or column charts, pie charts, diagrams, illustrations and photographs.

Tables and figures are usually redrawn by RCNi. The editorial team at RCNi may decide not to keep all tables and figures supplied. Regarding permission to reproduce existing materials, refer to the 'Permissions and ethics' section of this document. Images retrieved from the internet cannot be used.

Author guidelines RCNi

References
It is your responsibility to ensure that your article is accurately and appropriately referenced using the current literature and primary sources. Unless you are citing seminal references, you must use references published within the last ten years. References to Wikipedia articles are not accepted. The reference list must be placed at the end of the article under the subheading 'References'. Any formatting from reference management software, such as EndNote or Reference Manager, must be removed before submission.

Please adhere to the Harvard system of referencing, exemplified below.

Reference citations in the article
- **One author:** Community-acquired pneumonia has high morbidity and mortality rates (Müller 2015).
- **Two authors:** Blandin and Pepin (2017) argue that grief occurs in anticipation of multiple losses over time.
- **More than two authors:** Stokes et al (2017) suggest that trauma-informed care is an area where nurses' knowledge is limited.
- **If two or more references are cited simultaneously, they must be cited in chronological order from oldest to most recent:** Differing management approaches can be a barrier to pain management (Neville and Roan 2014, Morley et al 2015).
- **If there are two or more references to the same author, the order must also be chronological:** For adults with substance use disorder, National Institute for Health and Care Excellence (2007, 2011) guidelines support the use of brief interventions.

References in the reference list
References must be listed in alphabetical order. If there are two or more references to the same author, they must be cited in chronological order from oldest to most recent. Please include digital object identifiers (DOIs) if available.

Journals
- **One author:** Müller F (2015) Oral hygiene reduces the mortality from aspiration pneumonia in frail elders. Journal of Dental Research. 94, 3 Suppl, 14S-16S. doi: 10.1177/0022034514552494
- **Two authors:** Blandin K, Pepin R (2017) Dementia grief: a theoretical model of a unique grief experience. Dementia. 16, 1, 67-78. doi: 10.1177/1471301215581081
- **Three authors:** Hunt PA, Greaves I, Owens WA (2006) Emergency thoracotomy in thoracic trauma: a review. Injury. 37, 1, 1-19. doi: 10.1016/j.injury.2005.02.014
- **More than three authors:** Stokes Y, Jacob JD, Gifford W et al (2017) Exploring nurses' knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research. 4. doi: 10.1177/2333393617734510

Books
Webster S, de Wreede R (2016) Embryology at a Glance. Second edition. Wiley-Blackwell, Oxford.

Chapters in books
McErlean L (2017) The digestive system. In Peate I, Nair M (Eds) Fundamentals of Anatomy and Physiology for Nursing and Healthcare Students. Second edition. John Wiley & Sons, Chichester, 257-298.

Websites
Children's Liver Disease Foundation (2020) About Us. childliverdisease.org/about-us (Last accessed: 11 January 2022.)

NICE guidelines
National Institute for Health and Care Excellence (2019) Delirium: Prevention, Diagnosis and Management. Clinical guideline No. 103. NICE, London.

Plagiarism

Plagiarism is the unreferenced use of other people's work or ideas – published or unpublished – or of your own published work. Plagiarism includes copying or paraphrasing a sentence, paragraph, box, table or figure from another person's (or your own) work without appropriate referencing. Your research article must be your own work and should be written in your own words. All mentions of other people's work must be attributed to the original author(s) and referenced in full. Direct quotes must be reproduced verbatim between single quotation marks.

All research articles submitted for publication in the 'evidence & practice' section of RCNi journals are checked for plagiarism using automated software. This generates a 'similarity report' which shows any matches between text in your article and text in published content. The article may be rejected based on the similarity report.

Permissions and ethics

If you plan to use substantial sections of text or illustrations from a source protected by copyright, you must obtain written permission from the copyright holder before submission. If permission has not been secured, we may not be able to use the material.

Figures previously published elsewhere may be used but will usually be protected by copyright, so you must seek permission from the publisher to reproduce them before submitting the article. Where permission has been granted this should be acknowledged in the text and evidence should be provided to RCNi. Please allow sufficient time to gain permission from the publisher, which can take up to 12 weeks.

All patient names should be changed to pseudonyms to protect patient confidentiality. If your article includes a case study based on a real patient, you must obtain their written consent to use their details in the article.

If you supply photographs with your article, you must obtain consent from the people in the photographs.

For further information on RCNi's ethical guidelines go to **rcni.com/submit-an-article-ethics**
RCNi is a member of the Committee on Publication Ethics (COPE), which advises editors and publishers on all aspects of publication ethics. For more information go to **publicationethics.org**

Authorship

To be credited as an 'author', three minimum requirements must be met:
- Making a substantial contribution to the work.
- Being accountable for the work and its published form.
- Having reviewed and approved the article before submission.

Author guidelines RCNi

If people involved in an article do not meet these requirements, they should be listed in an 'Acknowledgement' and their specific contribution to the article stated. See below under 'Acknowledgements'.

In a co-authored article, it is the authors' responsibility to decide jointly both the order of authors and whether a person credited as an author should be listed in an 'Acknowledgement' instead. This must be decided before submitting the article. All authors must meet the minimum requirements stated above.

The corresponding author is responsible for notifying RCNi of changes to authorship.

Conflict of interest

Each author must declare any interest, financial or other, that could have inappropriately influenced their work. If there are no conflicts of interest to declare, a statement such as 'None declared' should be provided.

Acknowledgements

Short acknowledgements can be made to people, organisations or groups of people. The acknowledgement should specify how they have contributed to the article. If you wish to acknowledge a specific person or organisation, you must contact them and ask them to approve, in writing, the appropriateness of the acknowledgement, the spelling of names and the correctness of titles.

Submitting your article

Deadlines

Editorial deadlines are set to allow time for research articles to be peer reviewed and edited before their planned publication. Please keep to the deadlines agreed with the commissioning editor so that the production schedule and the quality of the content can both be maintained. If for any reason you are unable to meet the agreed deadline, please inform the commissioning editor as soon as possible.

Preparing your article

Articles must be submitted as Microsoft Word documents with double-spaced lines, single returns at the ends of paragraphs, margins of 1.5 inches and numbered pages. Please remember to keep a copy for your records.

Boxes and tables should be submitted as editable text, not as images embedded in Word documents. Boxes, tables and figures must be inserted in a separate section at the end of the article after the references. If a table or figure is very large, it can be supplied as a separate document.
If a figure has been created in a Microsoft Office application (Word, PowerPoint, Excel), it should be supplied in its original format. Other figures need to be supplied in one of the following formats: EPS, PDF, TIFF or JPEG.

Please ensure that figures, including photographs, are submitted at the largest size available (the more megapixels the better). Please do not embed photographs in Word documents as this may reduce the size and quality of the file. Your smartphone or computer may give you the option to choose the file size to send. If so, always select 'large' or 'original'. If you are not given this option, the file will most likely be sent at the largest size available. Please do not make the file smaller than it is, since this often makes it unusable.

Author guidelines

RCNi

Online submission
Articles must be submitted through our online submission system, Editorial Manager. To access Editorial Manager, select your chosen journal at **rcni.com/submitting-an-article**
Your submission will be acknowledged by email and you will be able to track its progress online. Articles are assessed internally before being sent to external experts for peer review.

You can expect to wait 12 weeks after the first acknowledgement before receiving a response. This will be either provisional acceptance without revision, a request for revision or a letter explaining that your article has been declined.

Copyright
If your article is provisionally accepted, you will be asked to complete an author form and sign a publisher's agreement. The publisher's agreement assigns copyright of your article to RCNi. Articles will not be published without a signed publisher's agreement from each author.

Article proofs
Before publication, you will be asked to proofread an edited version of your article and answer any editorial queries raised. The in-depth editorial process at this stage may generate queries in addition to those generated by the peer-review process. You will then receive confidential Word proofs for final approval.

Publication
Articles are published online. The online article is the version of record and is fully citable. Once your article has been published online, you will receive a watermarked PDF for your personal use only. Your article may also be published in a print issue of the journal at the editor's discretion.

The publisher's agreement you have signed protects you from someone taking your work and using it unfairly. If someone wants to reprint or adapt your work or place it on a website, they will need to obtain permission from RCNi and credit you as the original author. RCNi does not usually allow articles published in its journals to appear on third-party websites. RCNi generally supports reprinting provided the proposed use is appropriate. We also encourage you to upload the final provisionally accepted version of your article on your institution's online repository, but only six months or more after online publication.

For further information about how your article can be promoted, including open access publication, go to **rcni.com/author-policies**

Contacts
For technical questions about submitting your research article, contact Julia Mariappa (+442088723171, **julia.mariappa@rcni.com**) for Nursing Standard or Helen Hyland (+442088723138, **helen.hyland@rcni.com**) for RCNi's specialist journals.

For any other question, contact the editor of your chosen journal. To find their details, go to your chosen journal in the 'Explore our journals' section at **rcni.com/write-us/explore-our-journals**

Appendix C. Author guidelines for submission: theoretical driven (main) research project

Psychology of Sexual Orientation and Gender Diversity.

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission
To submit to the editorial office of M. Paz Galupo, please submit manuscripts electronically through the Manuscript Submission Portal in Word Document format (.doc).
Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available.

Manuscript types
Psychology of Sexual Orientation and Gender Diversity® (*PSOGD*) accepts a variety of article types consistent with the journal's mission, including:
Standard articles containing a maximum of 7,500 words of text. These will be the most typical articles.
Longer, monograph-style articles containing a maximum of 12,000 words of text. These longer contributions will not be typical and to be considered, must provide a particularly enhanced coverage of the topic addressed.
This can take the form of:

- especially extensive literature review with a methodological critique and/or public policy implications explicated
- description of an interlocked series of research projects
- synthesis of material on sexual orientation and gender diversity with material from other aspects of psychology and/or other disciplines
- similarly extensive contributions

AUTHORS MUST OBTAIN PRIOR APPROVAL OF THE EDITOR PRIOR TO SUBMITTING THIS ARTICLE TYPE.
Brief reports are research-oriented and contain a maximum of 4,000 words of text.
Case studies are clinically/practice-oriented (including industrial/organization practice) and contain a maximum of 3,000 words of text. All ethical and risk management considerations regarding informed consent, confidentiality, and other relevant concerns must be addressed. Case studies must also situate the case in question in relevant theoretical, empirical, and methodological matrices.
Letters to the editor should be limited to 500 words. In unusual circumstances, the founding editor may allow a longer limit with the author.
Commentaries may address developments in the behavioral sciences and related fields, the legal system, national or world events, as these pertain to the content areas of *PSOGD*. These should be a maximum of 1000 words, unless a longer length is allowed by the founding editor.

This list is not meant to be exclusive. Other article varieties may be accepted under unusual circumstances. However, authors must contact the editor prior to submission of any other article to discuss and get approval.
As a rule of thumb one double-spaced page of standard font and size text contains about 300 words. If submissions contain an unusually larger number of references for the article type and/or unusually large tables/charts/graphs, authors may be required to reduce these. "Words" refers to words and other symbols or characters.

Qualitative research
PSOGD welcomes a variety of methodologies in its submissions, including quantitative, qualitative, and mixed quantitative/qualitative methodologies.
All submissions are expected to maintain word limits specific to the type of manuscript (see manuscript types); offer replicable methodology; involve an *N* commensurate with the purpose of the research and which allows reasonable inference; and be written in a concise and focused manner.
In particular, extensive quotations from research participants are ill-advised, and should be limited to a few which are especially evocative of key themes. The theme descriptions should be the predominant vehicle for conveying participants' responses in qualitative research.

Manuscript preparation
Review APA's Journal Manuscript Preparation Guidelines before submitting your article.
Since *PSOGD* first began publishing in 2014, a number of recurring questions and situations have arisen.
This material attempts to respond to these proactively, in the hope that potential authors have a clearer sense of *PSOGD's* expectations and procedures.
Please feel free to contact the editor with any inquiries about these topics below or others.
Masked submission
Nothing in your manuscript should indicate authors' identities, institutional affiliation, or other identifying features. Common examples include: naming the institution that granted institutional review board approval; citing by name previous publications on which the current submission explicitly builds; naming specific organizations that cooperated in data collection, etc.
The words "MASKED FOR REVIEW" should be substituted.
When masking earlier work on which the current submission is based, remember to remove the identifying citation both from the text and the references. Insufficiently masked submissions will be returned to authors for masking before being sent for review, which slows the review process.
If the article is accepted for publication, the identifying information can be added subsequently.
Please ensure that the final version for production includes a byline and full author note for typesetting.
Language guidelines
Authors should be cognizant that language and terminologies used to describe sexual orientation and gender diversity have been used in pejorative ways, have undergone transitions, may likely undergo more transitions, and should be used in ways that convey respect yet maintain precision.

When APA offers language guidelines or policy statements that address terminology, authors are generally expected to use these guidelines and statements. There are exceptions to this, such as accurately quoting or describing older literature which might use outdated or problematic terminology.
If atypical or non-standard language choices are made deliberately (e.g., using "they" as singular in order to be trans-inclusive), this should be explained and documented in a footnote to the manuscript.

Revisions

Revisions must be accompanied by a description of changes made, including previously rejected and rewritten papers incorporating feedback.
As the decision letters state, when submitting a revision, authors must include a letter or memo describing the changes made in response to reviewer and editor feedback. This letter should address all the points raised by the editor and reviewers. It is acceptable to disagree with feedback and reject or modify a requested change; this should be clearly stated, and a rationale provided for the disagreement.
Resubmission of a previously rejected manuscript is generally not recommended without consultation with the editor. If resubmission of a previously rejected manuscript is made, authors should note the manuscript number of the earlier rejected submission, and include the same full description of changes made as described in the above paragraph.
Revisions/resubmissions without a description of changes made will not be read and will be returned to authors with instructions to provide this description.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page.
After the abstract, please supply up to five keywords or brief phrases.
PSOGD encourages submissions from all countries and aspires to disseminate knowledge about sexual orientation and gender diversity internationally.
To this end, authors should submit abstracts and keywords in English and, if they wish, in addition provide abstracts in any other language(s) relevant to the submission in question.
Specifically, authors may submit abstracts and keywords in languages in addition to English in the following circumstances:

- When the research subjects or content matter involve non-English speaking populations
- When the authors are based in a non-English speaking country or comprise a multi-national team with some members from non-English speaking countries.
- There may be other circumstances where authors wish abstracts in other languages to be included. These should be reviewed and approved by the founding editor.

Note that all submissions must include an abstract and keywords in English.

Non-English language abstracts

PSOGD is committed to encouraging and disseminating scholarship on sexual orientation and gender diversity world-wide as much as is feasible. To facilitate this goal, authors working in a non-English speaking country, or whose sample is from a non-English speaking country, should submit another abstract in their other language, or that of the sample. This will appear below the English abstract if the article is published.

If authors or samples are from multiple non-English speaking countries, abstracts in all the relevant languages should be included. These additional abstracts need not be provided until the final accepted revision.
PSOGD does not have the resources to provide a final copyediting of non-English abstracts, so authors should carefully check the non-English abstracts.
PSOGD can publish the main article text only in English.

Public significance statement
Authors submitting manuscripts to PSOGD are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). This description should be included within the manuscript on the abstract/keywords page.

- View Guidance for Translational Abstracts and Public Significance Statements

Clinicians' Digest
Beginning in 2018, *PSOGD* will include a Clinicians' Digest section providing practitioners with clinically useful, yet scientifically robust ideas from articles published in the journal.
The Digest, consisting of one- or two-paragraph synopses of clinically relevant concepts from articles in that issue, presented together as one piece, is written by a rotating team coordinated by Christopher Martell, PhD, ABPP.
Authors of the source articles from which the Digest synopses are drawn have the prerogative to decline their articles' participation in the Digest. They are, however, strongly encouraged to allow their articles to be included in order to facilitate their findings being maximally useful to practitioners.
Digest authors will work with source articles' authors to maintain fidelity with the source article.
The synopses in the Clinicians' Digest are intended to be used with the source article and its abstract, but offer original clinically relevant ideas based on the source article.

Formatting
Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.
Additional guidance on APA Style is available on the APA Style website.
Below are additional instructions regarding the preparation of display equations, computer code, and tables.
Display equations
We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.
To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that

your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.
Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In online supplemental material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the text of the article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's insert table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic writing and English language editing services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.
Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.
Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting supplemental materials

APA can place supplemental materials online, available via the published article in the PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.
Examples of basic reference formats:
Journal article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Resolution

- All color line art and halftones: 300 DPI
- Black and white line tone and gray halftone images: 600 DPI

Line weights

- Adobe Photoshop images
    - Color (RGB, CMYK) images: 2 pixels
    - Grayscale images: 4 pixels
- Adobe Illustrator Images
    - Stroke weight: 0.5 points

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

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Publication policies

Duplicate publication

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

Splitting data sets; data fragmentation

Please read the Open Letter to Authors for APA Journals (PDF, 40KB), but especially, please note the following:

> **Duplicate/fragmented publication**. Duplicate publication involves publishing the same data more than once. Fragmented (or piecemeal) publication involves dividing the report of a research project into multiple articles. Duplicate or fragmented publications are misleading if they appear to represent independent instances. They can distort the scientific literature, especially in reviews or meta-analyses.
>
> On occasion, it may be appropriate to publish several reports referring to the same database. The author should inform the editor at the time of submission about all previously published or submitted reports so the editor can judge if the article represents a new contribution. Readers also should be informed; the text of an article should cite other reports that used the same sample (or a subsample) or the same data and methods.

Since *PSOGD* allows for longer submissions, up to 12,000 words, there should be few circumstances where publishing several pieces from the same data set is warranted. Data sets that have both quantitative and qualitative components should generally be published as a whole.

PSOGD recognizes, however, that some large data sets, for example as are common in epidemiological research, appropriately lend themselves to multiple publications. Authors are expected to contact the Editor before submitting a piece which may have fragmented data, provide a rationale for this, and obtain the Editor's consultation on the appropriateness.

Authors who undermine these guidelines by covertly splitting data sets and creating separate publications will be denied future consideration for *PSOGD* publication.

Submissions contingent on another article under development or review

If the submission is contingent on data under development or being published elsewhere, authors should wait until the underlying data is at least accepted for publication before submitting a secondary submission to *PSOGD*. For example, if authors rely on a measure whose reliability and validity data have not been published or are under review, authors should delay submission to *PSOGD* until acceptance for publication and final form of those underlying data are confirmed.

Submissions that rely on unpublished underlying data will be rejected without review.

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APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

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- For manuscripts funded by the Wellcome Trust or the Research Councils UK
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Ethical Principles

Previously published data

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

Availability of raw data

APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

On a case by case basis, *PSOGD*'s editor may request that authors provide all or some of the raw data on which research reported in a submission is based. This might typically occur at the request of a reviewer, or when the editor believes there is something unusual, atypical or unclear about the reported results.

Authors are expected to provide the raw data requested in a timely manner. Authors' unwillingness to do so will result in the submission's rejection. Data may not be considered proprietary.

Ethical principles certification

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

General expectations of submissions

Given the wide variety of manuscript types that *PSOGD* accepts, all of these recommendations may not be suitable for all submissions, but are most true for standard and longer research articles.

- **Clear description/intro.** Make certain readers are quickly oriented to the purpose and focus of your manuscript. Make sure that the words used to describe your purpose and focus are the same throughout the manuscript.
- **Literature review to set context.** The literature review should situate your work both in the literature on sexual orientation and gender diversity, and in the behavioral sciences more generally. It should include enough to make a compelling argument for why your study was needed, and should lead directly to your purpose and hypotheses/research questions. Too little, too much, or tangential literature review are common errors. Ensure that your sources present credible scientific findings.
- **Clear methodology.** Could others replicate it? Are the chosen methodologies adequately justified? Provide citations to support your rationale for selecting your given methodology and analytical strategy. Are your data appropriate for the study questions and analyses (e.g., adequate sample size)?

- **Information about measures.** Basic reliability/validity of measures should be summarized and, when possible, these data should be obtained from samples consistent with your study sample. Provide reasons for choosing the specific measures. In addition, report the number of items, scoring procedures, the directionality of scores (e.g., higher scores on this measure indicate higher...), and how scores are computed. If measures were modified in your study, describe the rationale for the modification, the specific modification, and whether this modification was guided by any theory or previous study's methods, and how the measure "behaved" in your study (e.g., reliabilities, factor scores).
- **Sample.** Describe clearly sampling and recruitment procedures. Describe demographics and other characteristics. Have you used up-to-date terminology?
- **Statistics.** Are your statistical results presented in a clear and accessible manner? Does your statistical plan map to your hypotheses? When programs other than SPSS or SAS are utilized to conduct the analyses, report the program (e.g., MPlus). Only identify quantitative results as significant when they meet the generally accepted minimum criterion of $p < .05$ (i.e., do not suggest that scores "trended toward significance" unless you did a trend analysis). Discuss missing data (i.e., amount and whether data were missing at random) and how missing data were addressed. Were the tables/charts/graphs etc. checked for accuracy?
- **APA Style.** Headings, references, citations, and tables/charts are frequently done incorrectly. Please check these carefully.
- **Copyediting.** Your submission should be free of spacing, formatting, grammatical, spelling, and other copyediting errors. Manuscripts judged to contain an unreasonable number of errors will be rejected without review.
- **Conclusions.** Are the conclusions that are drawn clearly supported by the data and congruent with the limitations of your methodology? It is a common mistake to reach beyond your data, especially when discussing implications for practice, advocacy, education, etc. However, not discussing the full implications of one's findings can be problematic as well. Strive for balance, but err on the side of caution. Attempt to relate the findings to conclusions reached in previous research but watch speculating beyond the data.
- **Limitations.** Do not minimize or avoid. Describe limitations directly, and when possible use your limitations as a springboard for recommendations for future research.

Note compliance with institutional review board and ethical requirements, without sacrificing masking of the manuscript.

Concise writing

Be concise and avoid expansive writing.

Journal space is at a premium. Please review your submissions to keep the writing as concise and focused as possible. The goal is to write just enough to fully communicate the integrity of your work.

Manuscripts with an unnecessarily verbose writing style will be returned to authors, unreviewed, for a more focused and shorter revision. This is also true of references, which should be sufficient to fully justify and contextualize the submission-but no more.

Tables, charts, figures etc. should similarly summarize and clarify, and contribute to the understanding of the research being presented beyond the information reported in

the text. If they do not do so, they serve no useful function and authors will be asked to condense or delete them.

Stylistic differences

Be aware of the stylistic differences between student and institutional papers versus journal publications. Papers that are initially prepared as student assignments, reports of research grant activities, internal institution documents, etc., are typically in formats and styles inconsistent with journal publication.

For example, faculty often expect student papers to demonstrate wide-ranging literature reviews and elaborate justifications of methodology and instrumentation; grant and institution-focused papers often address goals and issues uniquely relevant to those entities.

Such papers usually require considerable revision before they are appropriate journal submissions. This is almost always in the direction of sharper focus, more concise writing style, and significant shortening.

Faculty and funding sources usually expect such student and institutional paper authors to demonstrate skill sets and goals that go beyond concise presentation of the material. Journal publications seek only concise presentation of the material.

Please edit your work accordingly before submitting it.

Other information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Appendix D. Service improvement project lay summary

The NHS long-term plan resulted in an increase in funding to different NHS services to provide better choice of care to all patients, of all ages. They hoped to achieve this through increasing patients' access to mental health services and increasing healthcare professionals' skills and knowledge.

Discussions between the trainee and consultant clinical psychologist from Older Persons Community Mental Health NHS service in South Buckinghamshire exposed gaps between patients experiencing hallucinations[†] and those referred for psychological support. To explore this further, the trainee created a three-phased project: *Phase 1* – audit the number of patients experiencing hallucinations and those referred to psychological service. *Phase 2* – survey healthcare professionals' views on older persons experiencing hallucinations. *Phase 3* – deliver a 20-mintue training session to address healthcare professionals' skills and knowledge and promote psychological therapies.

Between 2015-2021, only 6% of patients who experienced a hallucination were referred to psychological services, of whom only 1.3% received psychological interventions. The survey showed healthcare professionals felt psychological intervention was helpful for patients, but they did not feel confident referring patients to psychological services and discussing these benefits. The training session helped increase healthcare professionals' confidence and likelihood of referring patients with distressing hallucinations to psychological services.

Further recommendations for the service include a physical resource for healthcare professionals, which could include suggestions on ways to engage patients experiencing distressing hallucinations, a flow-diagram on how/when to refer someone to psychological services and key information to ascertain prior to referring. Additionally, the service would benefit from collaborating with third sector organisations and providing healthcare professionals further training and resources.

[†]*Hallucinations are sensory experiences which appear real to the person, but there is no external stimulus, for example, someone might hear a voice that no one else in the room can hear.*

Appendix E. Audit approval confirmation

FW: Department of Psychology

RK Rhodes Katie (RNU) Oxford Health
To Izon Emma (RNU) Oxford Health; Dow Rebecca (RNU) Oxford Health; Collett Nicola (RNU) Oxford Health

You replied to this message on 16/04/2022 12:10.
Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

Audit report template (2018).docx
.docx File

Good morning all,

Your audit has been approved.

Please complete a report upon completion of your audit. I have attached a template for your convenience.

Kind Regards,

Katie Rhodes
Senior Team Administrator
Buckinghamshire Mental Health Directorate
Oxford Health NHS Foundation Trust
The Whiteleaf Centre | Bierton Road | Aylesbury | HP20 1EG

Caring, Safe and Excellent. If you are interested in becoming a member of our Foundation Trust please join us online at www.oxfordhealth.nhs.uk



From: Khosla Vivek (RNU) Oxford Health <Vivek.Khosla@oxfordhealth.nhs.uk>
Sent: 20 April 2021 07:57
To: Rhodes Katie (RNU) Oxford Health <Katie.Rhodes@oxfordhealth.nhs.uk>
Subject: Re: Department of Psychology

Happy to approve

Best wishes

Vivek
Dr Vivek Khosla
Clinical Director (Bucks Mental Health) and Consultant Forensic Psychaitrist

Appendix 1: Quality Improvement/Clinical Audit Proposal Form

NHS
Oxford Health
NHS Foundation Trust

Quality Improvement/Clinical Audit Proposal Form

Please register your audit or service evaluation with your directorate Quality lead before you start your project who maintain a central database of all audit activity.

Title	Understanding older adults who experience hallucinations access to psychological intervention.		
Directorate	Department of Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford, OX3 7JX	**Team / Ward / Unit**	Older Adult Psychological Services (BUCKINGHAMSHIRE)
Name and Title of project lead(s)		Dr Emma Izon – Trainee Clinical Psychologist, Dr Rebecca Dow – Consultant Clinical Psychologist Dr Nicola Collett - Clinical Psychologist	
Contact telephone number		-	
Contact email address		Emma.izon@oxfordhealth.nhs.uk	
Supervising Consultant / Service Manager		Dr Rebecca Dow – Consultant Clinical Psychologist	
Proposed start date		20 April 2021	
Proposed finish date		03 December 2021	
This project is a:			
☒ First audit/ quality improvement	☐ Re-audit/ quality improvement If yes, date of last audit/ quality improvement _____		
What is the resource implication for carrying out project (estimate staff hours, designation, grade, and cost)	Estimated staff hours will be minimal, with John Pimm and David Tilbrook aware of the project. Resource implication will involve: - Support from CRIS with the audit and searching Carenotes. - Focus groups with staff from Early Intervention services using Microsoft TEAMS to support with questionnaire refinement. - A brief questionnaire delivered remotely to Buckinghamshire staff in the Older Adult CMHT service		
Reason for audit or evaluation (tick all that are applicable)			
☐ National priority	☐ Trust priority	☐ Directorate priority	☐ CCG priority
☐ NICE guidance	☐ SIRI recommendation	☒ Other (please state) This project is service-driven, with the need identified in meetings by the consultant clinical psychologist. Meetings with the consultant clinical psychologist highlighted gaps between those offered psychological interventions and diagnosis, which is particularly important with the increase in funding and CMHT transformation plan.	

If NICE guidance, please state which guidelines: _____

Background to Project

Aims

The 10-year plan aims to address inequalities in service provision, provide appropriate mental health support to all ages, and upskill staff. The South Buckinghamshire older adult (OA) service play a key role in addressing these plans and providing equality for their patients. This project will conduct the first audit within the service exploring the number of patients in the local Community Mental Health Teams (CMHT): under a psychosis cluster, with the term "hallucinations" attached and those referred to psychological therapy. The literature exploring barriers to accessing psychological support for OA experiencing hallucinations is scarce. Understanding staff perceptions from the CMHT who support OA's will be important in highlighting initial barriers. This project will produce recommendations to create meaningful change and improve access and equality for patients.

Literature Summary

The National Health Service (NHS) 10-year plan looks to support the adoption of more rights-based care based on greater choice and engaging early with communities and all ages to address inequalities (NHS, 2019a). Improvements include providing choice about the care patients receive. The NHS sets out plans for prioritising mental health, expanding Increasing Access to Psychological Therapies (IAPT, NHS, 2019b) and upskilling staff with knowledge and skills (2019a). Therefore, it is vital that services are responsive to older adults (OA) with mental health needs and staff have the appropriate knowledge to facilitate this.

Hallucinations are perceptual experiences within a sensory modality but without the external stimulus (American Psychiatric Association, 2013). Research estimates that one in ten people hear a voice in their lifetime (Maijer et al., 2018; Hearing Voices Network, 2020), which can trigger significant distress. Hallucinations are evident in neurological, medical and psychological conditions, as well as nonclinical populations (Badcock et al., 2020). They are more prevalent in OAs across several presentations: dementia (O'Brien et al., 2020), no formal education (Subramaniam et al., 2016), and those experiencing difficulties with eyesight, hearing or deafness (Linszen et al., 2019; Subramaniam et al., 2016). The prevalence of psychotic symptoms such as hallucinations among OAs ranges between 2.6% and 10% (Subramaniam et al., 2016). Hallucinations occur in about 30% of patients with Alzheimer's disease and 60% with Lewy body dementia (Sinclair et al., 2019).

Hallucinations can cause significant distress and impairment for OA's and have been associated with increased social withdrawal and falls (Badcock et al., 2020). OAs who experience psychological distress are largely treated with pharmacological interventions (Healthcare Commission, 2009), which can cause severe physical disability (Huybrechts et al., 2012). Specialist Early Intervention services supporting people with experiences such as hallucinations are not typically commissioned to support OAs. Guidelines for treating hallucinations are managed within specific conditions, with no specific treatment beyond general measures (e.g., education, reassurance, physical, and medication review) and do not acknowledge patient preference. For example, the National Institute for Clinical Excellence (NICE) guidelines (2014) for schizophrenia suggest antipsychotic medication in combination with psychological interventions (family intervention, individual CBT). In comparison to distressing hallucinations in Parkinson's disease, psychological interventions are not mentioned. Badcock and colleagues (2020) argue that interventions for OAs experiencing hallucinations are based on clinical judgment, which creates further disparity and uncertainty for best practice guidance.

Staff and Service Involvement

OA's exhibit fewer help-seeking behaviours and are less likely to be referred to or receive psychological support, when compared to the general population (Age UK, 2016). Healthcare professionals may act as a barrier for OAs in facilitating access of treatment (Bennett et al., 2017). They may hold perceptions that psychological therapy is ineffective for OAs (Badcock et al., 2020; Wuthrich & Frei, 2015), lacking knowledge of associations between hallucinations, trauma and bereavement (Badcock et al., 2020). Ince et al. (2016) found that organisational constraints created additional barriers, for example lack of resources, high caseloads, and workload pressures on staff. These factors can influence healthcare professionals' alignment to the biomedical model for treatment of mental distress and may result in a focus on symptom reduction rather than recovery. Recommendations for supporting OA's experiencing hallucinations include training for healthcare professionals to: clarify any myths, help them to recognise distress and symptoms early and refer to specialist services (Badcock et al., 2020). Berry et al. (2020) recommend working with staff to increase psychological mindedness and approaches to care. Initial steps include understanding beliefs healthcare professionals hold about therapy for OA's experiencing hallucinations.

Standard(s) for audit or quality improvement

(please list all the standards which will be assessed)
Data Management Strategy Surveys that are answered online will be stored anonymously on SurveyMonkey. Questionnaires that are completed in person will be anonymised and stored in a locked filling cabinet within an NHS service. Advice from R&D will be sought to conform to the highest ethical standards.

Continued space for standards/ objectives...
Objectives:

1. How many patients in South Buckinghamshire OA CMHT: fall into a psychosis cluster diagnosis, experience hallucinations, and have been referred to psychological therapy?
2. What are healthcare professionals' beliefs about psychological therapy for OA's experiencing hallucinations?
3. What will aid CMHT staff in recognising and normalising hallucinatory experiences for OAs?

Please state source of standards
Questionnaires that are completed in person will be anonymised and stored in a locked filling cabinet within an NHS service. Advice from R&D will be sought to conform to the highest ethical standards.

Scope and Methodology for Project

Stage 1. Audit

The South CMHT Older Adult service currently has 446 patients. The trainee has access to Carenotes and will investigate how many patients fall into a psychosis cluster diagnosis, and how many have a formal diagnosis. This information will be accessible on "Outcomes" or "Patient info" in Carenotes. A keyword search will be conducted to identify the number of patients in the service with "hallucination" experiences. A manual search will be conducted where the term is mentioned for each patient in their "correspondence" or "clinical notes". This process will be operationalised prior to the audit. The trainee has access to the psychological therapies referrals and will be able to assess the number of patients in the psychosis cluster diagnosis. The trainee will be able to match any cases of patients with the keyword "hallucinations", who were referred to psychology.

Stage 2. Questionnaire

Considering the current literature, reviewing a key barrier, such as this teams' perceptions would be key. This would help to identify whether further training or collaboration needs to be introduced to remove any potential barriers. This project will employ quantitative methods through a questionnaire for staff who have direct contact with OA (see Appendix 1 and 2). Mental health professionals (aged 18+) working in CMHT across South Buckinghamshire Oxford Health NHS will be invited to complete a questionnaire about treatment options and causes for OA (aged 65+) experiencing hallucinations. Participants will have the opportunity to complete the questionnaire online, or over the phone. Staff will be approached using an opportunistic approach to sampling. The involvement of Research and Development (R&D) and research champions will be sought. All analysis will be conducted using SPSS 27.0, focussing on demographics, descriptive statistics, and outcome measures.

Stage 3: CMHT Transformation Plans / Implementation

- Recommendations for routine data collection of how/what to ask and distress associated with hallucinations. This could result in a specific assessment tool to aid CMHT staff in recognising and normalising hallucinatory experiences for OA.
- Training on referring to psychology but also understanding hallucinations. This could incorporate destigmatising, demystifying facts about OA experiencing hallucinations. This project may highlight the need for closer collaboration between CMHT, psychological services and better links with third sector organisations (e.g., The Hearing Voices Network)
- The results and evaluation will be fed back to stakeholders. It will be important to share psychological perspectives on hallucinations across disorders. We will look to produce a lay summary and publish our findings in an academic journal.

How are you going to collect the data (tick all that are applicable)			
☒ Case notes (paper/ electronic)	☐ Observations	☒ Patient/ Staff Survey	☒ Other (please state) CRIS system
Data Protection Act			
Please tick to confirm "yes" you will comply with: ☒ All data collected will be anonymised ☒ No patient or staff identifiable data will be reported			
Ethics Screening			
Gather any information about a patient beyond that collected in routine patient care	☐ Yes ☒ No		
Pose any risk for or burden on a patient beyond those of his/her routine patient care	☐ Yes ☒ No		
Infringe on any patient's rights	☐ Yes ☒ No		
Risk breaching any patient's confidentiality or privacy	☐ Yes ☒ No		
Involve the use of any untested clinical or systems intervention	☐ Yes ☒ No		
Do you intend to publish the findings?	☒ Yes ☐ No		
Requested Support from the Quality and Audit Team (tick all that are applicable)			
☐ Design data collection tool		☒ Data collection	
☒ Data analysis		☐ Report writing	
☐ Power point presentation design		☐ None	

Quality and Audit Team Contact Details	
Emma Lofthouse – Tel: 07500 784 326 Liz Cheal – Tel: 07900 657 607 Clinical.audit@oxfordhealth.nhs.uk	**Corporate Directorate (Quality & Audit Specialists)**
Steve McCourt Steven.McCourt@oxfordhealth.nhs.uk	**Lead for CQC Standards & Quality**
Sandra Parker - Tel: 07770 346 493 CommunityServices.QualityTeam@oxfordhealth.nhs.uk	**Community Services Directorate**
Jelena Ampofo - Tel: 07787 002 849 MH.AuditQI.QCG@oxfordhealth.nhs.uk	**Mental Health Directorates**

Rene Sidorov – Tel: 07881 512 409 Ayo Akinbola – Tel: 07554 517 959 Governance.ForensicService@oxfordhealth.nhs.uk	**Specialised Directorate (Forensic, Dental, LD, Pharmacy)**
Dr Samantha Sadler – Tel: 01865 901222 Senior Locality Lead, Clinical Psychologist, Cognitive Behavioural Psychotherapist and Dynamic Interpersonal Psychotherapist www.talkingspaceplus.org.uk Dr David Tilbrook CPsychol AFBPsS – Tel: 01865 901620 Principal Clinical Psychologist, Bucks PTP Step 4, DIT Therapist	**Psychology Therapies Pathway (PTP)**
CRIS.Admin@oxfordhealth.nhs.uk	**Clinical Record Interactive Search (CRIS) Team**

Appendix F. Operationalising the term "*hallucinations*"

Inclusion list	Exclusion List	Exclusion List continued
experiences hallucination	does not experience hallucination	doesn't experience hallucination
has hallucination	does not have hallucination	doesn't have hallucination
reports hallucination	does not report hallucination	doesn't report hallucination
experiences auditory hallucination	does not experience auditory hallucination	doesn't experience auditory hallucination
has auditory hallucination	does not have auditory hallucination	doesn't have auditory hallucination
reports auditory hallucination	does not report auditory hallucination	doesn't report auditory hallucination
experiences visual hallucination	does not experience visual hallucination	doesn't experience visual hallucination
has visual hallucination	does not have visual hallucination	doesn't have visual hallucination
reports visual hallucination	does not report visual hallucination	doesn't report visual hallucination
experiences olfactory hallucination	does not experience olfactory hallucination	doesn't experience olfactory hallucination
has olfactory hallucination	does not have olfactory hallucination	doesn't have olfactory hallucination
reports olfactory hallucination	does not report olfactory hallucination	doesn't report olfactory hallucination
experiences tactile hallucination	does not experience tactile hallucination	doesn't experience tactile hallucination
has tactile hallucination	does not have tactile hallucination	doesn't have tactile hallucination
reports tactile hallucination	does not report tactile hallucination	doesn't report tactile hallucination
experiences gustatory hallucination	does not experience gustatory hallucination	doesn't experience gustatory hallucination
has gustatory hallucination	does not have gustatory hallucination	doesn't have gustatory hallucination
reports gustatory hallucination	does not report gustatory hallucination	doesn't report gustatory hallucination
hears a voice	does not hear a voice	doesn't hear a voice
hears voice	does not hear voice	doesn't hear voice
hears a noise	does not hear a noise	doesn't hear a noise
hears noise	does not hear noise	doesn't hear noise
hears a sound	does not hear a sound	doesn't hear a sound
hears sound	does not hear sound	doesn't hear sound
sees a thing	does not see a thing	doesn't see a thing
sees thing	does not see thing	doesn't see thing
sees a figure	does not see a figure	doesn't see a figure
sees figure	does not see figure	doesn't see figure
sees a shadow	does not see a shadow	doesn't see a shadow
sees shadow	does not see shadow	doesn't see shadow
reports odd taste	does not report odd taste	doesn't report odd taste
reports an odd taste	does not report an odd taste	doesn't report an odd taste
has strange	does not have strange	doesn't have strange
experiences strange	does not experience strange	doesn't experience strange
reports strange	does not report strange	doesn't report strange
has unusual	does not have unusual	doesn't have unusual
experiences unusual	does not experience unusual	doesn't experience unusual
reports unusual	does not report unusual	doesn't report unusual

Appendix G. Staff questionnaire

UNIVERSITY OF OXFORD

NHS Oxford Health NHS Foundation Trust

You have been invited to participate in a project carried out by Dr Emma Izon, who is a Trainee Clinical Psychologist at the University of Oxford and working with Dr Becci Dow at South Buckinghamshire Older Adults Psychological Service.

We are interested in **your** experiences in the South Bucks CMHT service and what **you** think about the treatment offered to **older adults with experiences of distressing hallucinations**. It is important to emphasise, that this is an anonymous questionnaire, therefore anything you answer will be deemed confidential.

Hallucinations –having what seem like real experiences of hearing, seeing, feeling, smelling, or tasting things that other people do not.

Age ____ **Gender** Male □ Female □ Gender nonbinary □ Prefer not to answer □

Job title (tick one) CPN □ Social worker □ Staff nurse □ Psychiatrist □ Care co-coordinator □ Support worker □ Team manager □ Occupational therapist □ Psychologist □ Other □ _____

Length of employment in current role < 1 year □ 1-2 years □ 3-5 years □ 6-10 years □ > 10 years □

How often do you ask about hallucinations? At assessment only □ I don't ask □ Other _____ □

How do you find asking clients? Completely comfortable □ Unsure □ Not comfortable □

How many older adults on your current caseload have experiences of hallucinations (approx.)_____

Do you think psychological intervention could be helpful? No □ Yes □

How could psychology help with distressing hallucinations? _____

_____

Have you previously referred anyone experiencing distressing hallucinations to psychology? No □ Yes □

If yes, please describe your experiences of the referral process_____

_____

How helpful do you think the following treatments are for older adults with experiences of distressing hallucinations?
(0=not helpful, 100=very helpful)

	0%	25%	50%	75%	100%
1. Medication					
2. Psychological Therapy					
3. Combined *(medication and therapy)*					

Please mark your answer with a 'X' on the line

Regarding older adults with distressing hallucinations, how much do you believe? (0=not at all, 100=very true)

	0%	25%	50%	75%	100%
1. They would not engage in psychological intervention					
2. Psychological intervention would cause more harm/distress					
3. There would be no improvements from psychological intervention					
4. Waiting lists for psychology are too long					
5. Younger patients should be prioritised					
6. They are too complicated for psychological intervention					

Regarding older adults with distressing hallucinations, how confident are you? (0=not at all, 100=very confident)

	0%	25%	50%	75%	100%
1. Asking about their experiences of hallucinations					
2. Working with this population					
3. Explaining what psychological intervention would involve					
4. Discussing the pros and cons of medication					
5. Discussing the pros and cons of psychological intervention					
6. Referring someone to psychological services					

As people are very different, there is no correct answer for this question. Below is a list of possible causes for hallucinations. Please indicate how much you agree or disagree by ticking one of the boxes.

What factors do you think contribute to the development of hallucinations for older adults?	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Drug or alcohol use					
Traumatic event in childhood (e.g., loss of a loved one, abuse, neglect)					
Traumatic event in adulthood (e.g., loss of a loved one, bereavement, abuse)					
Recent stress (e.g., financial problems, relationship problems, work stress)					
A personal sensitivity (e.g., bottling feelings up, overthinking, unstable personality)					
Family history (genes)					
Chemical imbalance in the brain or brain disease					
The result of religious/spiritual forces					
Other _____					

How would you feel about referring older adults with hallucinations to psychology? Completely comfortable □ Unsure □ Not comfortable □

What factors would influence your decision to refer (tick your top 3)

Evidence base □	Patient's preference □	Resources/availability □	Understanding what psychological support looks like / how it works □
Clinical guidelines □	Current risk □	Training about hallucinations in older adults □	How psychological therapies can help □
Professional's experience □	Client's current presentation □	Support and more options to discuss potential referrals □	Hearing about good outcomes from psychological therapy □
MDT opinion □	Carers needs □	Quicker referral options □	Other _____ _____ □

What support would you like from psychology regarding older adults with distressing hallucinations?

_____
_____
_____

Any further comments regarding barriers to referring to psychology?

_____
_____
_____

Thank you for completing this survey.

If you have any questions about the study or would like more information, please contact:

Dr Emma Izon (Trainee Clinical Psychologist) – emma.izon@oxfordhealth.nhs.uk
Dr Nicola Collette (Clinical Psychologist) Nicola.Collett@oxfordhealth.nhs.uk
Dr Becci Dow (Consultant Clinical Psychologist) Rebecca.Dow@oxfordhealth.nhs.uk

This service improvement project was granted approval from the Oxford Clinical Psychology Doctoral Training Programme at the University of Oxford and was registered with the local R&D office and given audit approval.

Appendix H. Additional statistics across the sample

Across the sample, concealment was significantly different between thee sexual orientations, $F(3, 25.29) = 17.67$, $p < .001$, $\eta_p^2 = .27$ (large effect size). There was a statistically significant increase in concealment from bisexual (1.72, 95% CI [0.94, 2.51], p=<.001) and queer participants (1.60, 95% CI [0.78, 2.42], p=<.001), when compared to gay men. As well as statistically significant increase in concealment from bisexual (1.33, 95% CI [0.61, 2.05], p=<.001), and queer participants (1.21, 95% CI [0.45, 1.97], p=<.001), when compared to gay women. Concealment was statistically significantly different for different genders, $F(2, 9.47) = 5.25$, $p = .006$, $\eta_p^2 = .07$ (medium-large effect size). There were statistically significant increase in concealment from TAO (1.00, 95% CI [0.21, 1.81], p=<.01) and cis-female participants (0.72, 95% CI [0.06, 1.38], p=.03), when compared cis-male participants. There were no other significant differences.

Table 10. Correlation matrix of independent, confounding and dependent variables of interest

		GHQ	Concealment to family subscale	Concealment to the world subscale	Age	TAO gender vs cis-female	Cis-male vs cis-female	Lesbian vs Bisexual	Gay man vs Bisexual	Queer vs Bisexual
GHQ	Pearson Correlation		.130	.071	-.097	.155	.121	-.090	.095	-.038
	Sig. (1-tailed)		.055	.194	.119	.029*	.069	.137	.124	.320
	N		151	150	151	151	151	151	151	151
Concealment to family	Pearson Correlation	.130		.469	-.015	-.136	.186	.239	.265	-.190
	Sig. (1-tailed)	.055		.000**	.428	.048*	.011*	.002*	.000**	.010*
	N	151		150	151	151	151	151	151	151
Concealment to the world	Pearson Correlation	.071	.469		.160	-.125	.208	.249	.340	-.206
	Sig. (1-tailed)	.194	.000**		.025*	.064	.005*	.001**	.000**	.006*
	N	150	150		150	150	150	150	150	150
Age	Pearson Correlation	-.097	-.015	.160		-.153	.256	.103	.208	-.005
	Sig. (1-tailed)	.119	.428	.025*		.031*	.001**	.105	.005*	.477

	N	151	151	150		151	151	151	151	151
TAO gender vs cis-female	Pearson Correlation	.155	-.136	-.125	-.153		-.285	-.189	-.230	.351
	Sig. (1-tailed)	.029*	.048*	.064	.031*		.000**	.010*	.002*	.000**
	N	151	151	150	151		151	151	151	151
Cis-male vs cis-female	Pearson Correlation	.121	.186	.208	.256	-.285		-.274	.806	-.264
	Sig. (1-tailed)	.069	.011*	.005*	.001**	.000**		.000**	.000**	.001**
	N	151	151	150	151	151		151	151	151
Lesbian vs Bisexual	Pearson Correlation	-.090	.239	.249	.103	-.189	-.274		-.221	-.316
	Sig. (1-tailed)	.137	.002*	.001**	.105	.010*	.000**		.003*	.000**
	N	151	151	150	151	151	151		151	151
Gay man vs Bisexual	Pearson Correlation	.095	.265	.340	.208	-.230	.806	-.221		-.270
	Sig. (1-tailed)	.124	.000**	.000**	.005*	.002*	.000**	.003*		.000**
	N	151	151	150	151	151	151	151		151
Queer vs Bisexual	Pearson Correlation	-.038	-.190	-.206	-.005	.351	-.264	-.316	-.270	
	Sig. (1-tailed)	.320	.010*	.006*	.477	.000**	.001**	.000**	.000**	
	N	151	151	150	151	151	151	151	151	

******** *Correlation is significant at the 0.01 level (1-tailed)*

*****Correlation is significant at the 0.05 level (1-tailed)*

Note. Cis-female gender and Bisexual sexual orientation were used as the dummy variables within the multiple hierarchical region analysis. Concealment to family and to the world were two subscales from the concealment measure (The Outness Inventory, Mohr & Fassinger, 2000). Abbreviations. Trans and Other = TAO; General Health Questionnaire = GHQ.

Appendix I. Additional statistics across the sample across the LGBTQ+ Jewish group

Across the LGBTQ+ Jewish group, concealment was significantly different between thee sexual orientations, $F(3, 11.27) = 8.00$, $p < .001$, $\eta_p^2 = .27$ (large effect size). There was a statistically significant increase in concealment from bisexual (1.64, 95% CI [0.53, 2.76], p=<.001) and queer participants (1.44, 95% CI [0.30, 2.58], p=.006), when compared to gay men. As well as statistically significant increase in concealment from bisexual (1.33, 95% CI [0.26, 2.41], p=.007), and queer participants (1.13, 95% CI [0.37, 2.23], p=.039), when compared to gay women. There were no other significant differences.

Table 11. Correlation matrix of independent, confounding and dependent variables of interest for the LGBTQ+ Jewish Group

		Concealment	Concealment to family subscale	Concealment to the world subscale	Age	TAO gender vs cis-female	Cis-male vs cis-female	Lesbian vs Bisexual	Gay man vs Bisexual	Queer vs Bisexual	Religious Identity subscale	Cultural Identity Subscale	GHQ
Concealment	Pearson Correlation				.040	-.249	.114	.261	.354	-.221	.019	.089	.121
	Sig. (1-tailed)				.371	.019*	.173	.014*	.001**	.033*	.438	.232	.162
	N				70	70	70	70	70	70	70	70	69
Concealment to family	Pearson Correlation				-.121	-.198	.070	.223	.258	-.196	-.105	-.071	.164
	Sig. (1-tailed)				.159	.050*	.281	.032*	.016*	.052	.194	.280	.089
	N				70	70	70	70	70	70	70	70	69
Concealment to the world	Pearson Correlation				.017	-.221	.111	.242	.325	-.246	-.052	.093	.067
	Sig. (1-tailed)				.445	.034*	.181	.023*	.003*	.021*	.335	.224	.293
	N				69	69	69	69	69	69	69	69	69
Age	Pearson Correlation	.040	-.121	.017		-.234	.299	.003	.257	-.046	-.020	.039	-.173
	Sig. (1-tailed)	.371	.159	.445		.006*	.026*	.489	.016*	.353	.433	.373	.078
	N	70	70	69		70	70	70	70	70	70	70	69

TAO gender vs cis-female	Pearson Correlation	-.249	-.198	-.221	-.234		-.369	-.215	-.272	.356	.024	-.102	.125
	Sig. (1-tailed)	.019*	.050*	.034*	.026*		.001**	.037*	.011*	.001**	.421	.201	.153
	N	70	70	69	70		70	70	70	70	70	70	69
Cis-male vs cis-female	Pearson Correlation	.114	.070	.111	.299	-.369		-.369	.739	-.275	.196	.178	.048*
	Sig. (1-tailed)	.173	.281	.181	.006*	.001**		.001**	.000**	.011*	.052	.070	.347
	N	70	70	69	70	70		70	70	70	70	70	69
Lesbian vs Bisexual	Pearson Correlation	.261	.223	.242	.003	-.215	-.369		-.272	-.332	.013	.050	-.028*
	Sig. (1-tailed)	.014*	.032*	.023*	.489	.037*	.001**		.011*	.002*	.456	.342	.411
	N	70	70	69	70	70	70		70	70	70	70	69
Gay man vs Bisexual	Pearson Correlation	.354	.258	.325	.257	-.272	.739	-.272		-.305	.083	.086	.035*
	Sig. (1-tailed)	.001**	.016*	.003*	.016*	.011*	.000**	.011*		.005*	.247	.239	.386
	N	70	70	69	70	70	70	70		70	70	70	69
Queer vs Bisexual	Pearson Correlation	-.221	-.196	-.246	-.046	.356	-.275	-.332	-.305		-.271	-.164	-.016*
	Sig. (1-tailed)	.033*	.052	.021*	.353	.001**	.011*	.002*	.005*		.012*	.087	.447
	N	70	70	69	70	70	70	70	70		70	70	69
Religious Identity subscale	Pearson Correlation	.019	-.105	-.052	-.020	.024	.196	.013	.083	-.271		.686	.097
	Sig. (1-tailed)	.438	.194	.335	.433	.421	.052	.456	.247	.012*		.000**	.213
	N	70	70	69	70	70	70	70	70	70		70	69
Cultural Identity Subscale	Pearson Correlation	.089	-.071	.093	.039	-.102	.178	.050	.086	-.164	.686		.062
	Sig. (1-tailed)	.232	.280	.224	.373	.201	.070	.342	.239	.097	.000**		.305
	N	70	70	69	70	70	70	70	70	70	70		69
GHQ	Pearson Correlation	.121	.164	.293	-.173	.125	.048*	-.028*	.035*	-.016*	.097	.062	
	Sig. (1-tailed)	.162	.089	69	.078	.153	.347	.411	.386	.447	.213	.305	

N	69	69	69	69	69	69	69	69	69	69	69	

****** Correlation is significant at the 0.01 level (1-tailed)*

****** Correlation is significant at the 0.05 level (1-tailed)*

Note. Cis-female gender and Bisexual sexual orientation were used as the dummy variables within the multiple hierarchical region analysis. Concealment to family and to the world were two subscales from the concealment measure (The Outness Inventory, Mohr & Fassinger, 2000). Cultural and religious identity were two subscales from the American Jewish Identity Scales measure (AJIS, Friedlander et al., 2010).

Abbreviations. Trans and Other = TAO; General Health Questionnaire = GHQ.