

A systematic review and thematic synthesis of qualitative literature on personal recovery and voice hearing

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Abstract

Background: Personal recovery literature has been influential in the conceptualization of emotional distress and service provision. While personal recovery in psychosis has been well-studied, voice hearing literature has not been reviewed to elucidate recovery processes.

Method: Five databases were systematically searched to identify relevant qualitative recovery literature. Twelve eligible studies were included in this review, and an appraisal tool was applied to assess quality. Thematic synthesis was used to examine the results.

Results: Three superordinate themes were found relating to ‘Recovery Phases’, ‘Recovery Facilitators’ and ‘Barriers to Recovery’. Papers included descriptions of finding voices distressing initially yet moving towards integrating and accepting voices. Searching for meaning versus seeking distance from voices were pivotal processes to recovery pathways. Enabling and disrupting recovery experiences are discussed within a proposed model.

Conclusions: Recovery in voice hearing is an individual and potentially ongoing process. Future research should seek to examine recovery factors in voice hearing longitudinally and add further evidence to the supportive role services can play in recovery and voice hearing.

KEYWORDS

auditory verbal hallucinations, psychosis, recovery, systematic review, thematic synthesis, voice hearing

1 | INTRODUCTION

1.1 | Hearing voices

Voice hearing, or auditory verbal hallucinations, is an incident of hearing a voice in the absence of an observable source, experienced as real for the hearer (Beavan, 2011). Voice hearing is commonly associated with a mental health diagnosis such as schizophrenia or borderline personality disorder (APA, 2013; Larøi et al., 2012).

However, estimates suggest 5% of the general population hear voices, with only a quarter meeting the criteria for a psychiatric diagnosis (Johns et al., 2004; Van Os et al., 2009). Such diagnoses are contested in mental health, with many questioning their validity (Cooke, 2017). Despite this, medical language is still dominant in describing the experiences, which will be discussed in this review. As such, terms such as ‘psychosis’ will be used to group experiences, but the intention is not to suggest the presence of illness.

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Voice hearers who use psychiatric services are more likely to be distressed by voices, hear voices more frequently, struggle to cope and seek distance from the voices (Beavan & Read, 2010; Kråkvik et al., 2015; Romme et al., 1992). However, research also suggests that hearing voices can be a beneficial experience for the hearer, further enriching their lives with positive content and companionship (Beavan & Read, 2010; Romme & Escher, 1989). As such, the experience of voice hearing has been conceptualized on a continuum of severity across the wider population (Johns & Van Os, 2001), with those whose experiences are at the more severe end of this continuum more likely to be highly distressed by voices, experience depression and at an increased risk of suicide (Birchwood et al., 2004; Birchwood & Chadwick, 1997; Kjelby et al., 2015).

1.2 | The mental health recovery movement

Traditionally within mental health, recovery has been defined within the medical model and the goal for mental health practitioners has been an absence of symptoms ('clinical recovery'; Law & Morrison, 2014). However, hearing voices can be an enduring experience and a cessation of voices contrasts with the aims of many voice hearers (Corstens et al., 2014). Instead, 'recovery' or 'personal recovery' has been conceptualized as an idiosyncratic process based on hope, rebuilding self and living a meaningful life (Pitt et al., 2007).

Gaining prominence through the service user movement, the values of person-centred, holistic and subjectivity underpinning recovery have influenced mental health treatment and research (Slade, 2009). Leamy et al. (2011) synthesized mental health recovery literature into five key processes by which recovery can occur: 'Connectedness', 'Hope and Optimism', 'Identity', 'Meaning' and 'Empowerment', known as the 'CHIME' model. Examples of innovation led by the principles of recovery included in the CHIME model are the proliferation of over 70 recovery colleges in the UK, a recognition of the benefits of peer support workers and the evaluation of specific recovery-orientated interventions in mental health services (Bird et al., 2014; Perkins et al., 2018; Slade et al., 2014). Recovery principles have also been incorporated into mental health policy in the UK, with the government making a commitment to 'test the key features of organisational practice to support the recovery of those using mental health services' (HM Government, 2011, p. 22). People being able to manage mental health difficulties and move towards 'individualised recovery' remains a key priority in National Health Service's (NHS) community mental health team framework (NHS England, 2019, p. 4). However, it is contested whether recovery ideas have been fully adopted in the UK (Slade et al., 2014).

1.3 | Recovery and psychosis

Psychosis has been defined as 'losing touch with the objective reality' and is an expression often used to refer to psychiatric diagnoses such as schizophrenia and bipolar affective disorder (Morrison et al., 2008).

Key Practitioner Message

- Voice hearers initially experienced distress relating to voices yet had the potential to move towards accepting voices and fostering positive self-identity.
- Searching for meaning and seeking distance from voices were predictive of divergent recovery pathways.
- A proposed model encompasses recovery-enabling (supportive organizations, sense making, changing beliefs, connection with others, empowerment) and recovery-disrupting (stigma, social isolation, disempowering services, negative impact of voices) experiences.
- Clinical services may be well placed to support voice hearers to make sense of their experiences and encourage recovery-facilitating processes.

Recovery has garnered much qualitative investigation in populations who have experienced psychosis (Leamy et al., 2011). A review of published experiential accounts suggested individuals viewed the process as recovery from the consequences of psychosis, as opposed to a 'cure' (Andresen et al., 2003). Key processes identified in this study were that of finding hope, re-establishing identity, finding meaning in life and taking responsibility for recovery. Similarly, Alyahya et al.'s (2022) qualitative review of consumer experiences suggested recovery in psychosis to be multi-faceted and idiosyncratic but included factors such as managing psychosis, building social and community networks, having a purpose and feeling empowered. For those experiencing a first episode of psychosis, a reduction or absence of psychosis symptoms has been perceived as contributing to recovery, alongside improvements in social relationships, autonomy and self-reliance (Eisenstadt et al., 2012). Within individuals who experience schizophrenia specifically (and may have experienced psychosis over a longer period), building one's identity and sense of self has been implicated as a crucial recovery process (Shea, 2010), with societal stigma being a barrier (de Wet et al., 2015; Lam et al., 2011).

More recently qualitative research on service user perspectives on recovery in psychosis has focussed on the recovery journey (Wood & Alsawy, 2018). Stages of recovery identified from previous literature moved from the person before psychosis, experiencing an episode, integrating and making sense of psychotic episodes and, lastly, rebuilding self and life. Social support, spirituality, agency, positive environment and holistic care from services were all implemented as facilitators to this journey. Corroborating previous findings, stigma was also seen as damaging to the process of recovery, alongside social deprivation, substance misuse and negative experiences of mental health services and medication. While these studies contain important experiences of recovery and psychosis, it has been argued that hearing voices is a meaningful experience that should not always be viewed as a symptom of psychosis or mental illness (Slade & Longden, 2015). Therefore, as a unique experience, related recovery processes for people who hear voices may differ.

1.4 | The phases of voice hearing

Romme and Escher (1989) previously proposed a three-phase model of coping with voices, based on survey responses collated from voice hearers. Respondents reacted to initial voice hearing with fright and confusion, constituting the 'Startling Phase'. Next, the 'Organisation Phase' is characterized by selecting and trialling different ways of coping, efforts to communicate with the voices and considering the meaning behind their experience. Lastly, once ongoing methods to manage the voices are established, individuals are thought to be in the 'Stabilisation phase'. In this final stage, the respondents were considered to have integrated the voices as part of the self and life and had a choice in their relationship with voices. While these findings are supported by qualitative responses, the authors do not outline the process, methods or analysis of arriving at these phases. Romme and Escher's model has been highly influential in understanding recovery processes in voice hearers and further research has partially corroborated these stages and sought to further elucidate recovery processes for voice hearers using more rigorous design and qualitative methods within psychiatric services (Bogen-Johnson et al., 2019; Milligan et al., 2013). While leading to major paradigm shifts, the work of Romme and Escher has largely focused on normalizing voice hearing and shifting the perception of it as a psychiatric symptom, rather than consolidating the research evidence to validate these phases, and to date, no review has synthesized this literature. Given voice hearing can be a distressing experience, impacting on functioning and leading some to seek support from mental health services (Beavan & Read, 2010), investigating recovery processes could inform the support available.

1.5 | Rationale and aims

While many voice hearers are not distressed by their voices, the term 'recovery' will still be used to refer to individuals leading a personally meaningful life of their choosing. As such, studies that include both clinical and non-clinical samples will be included in this review. Due to the idiosyncratic nature of recovery processes previously outlined in the literature, qualitative data will be privileged (Corstens et al., 2014). This review thus seeks to synthesize existing qualitative research on recovery processes in voice hearing to:

- I. Explore the journey and recovery processes relating to voice hearing;
- II. Identify core components (barriers and facilitators) in voice hearers' recovery.

2 | METHODS

2.1 | Eligibility criteria

As per the aims of this review, papers were identified that explored aspects of recovery from voice hearers' perspectives. Inclusion criteria

were as follows: (1) studies that sought to explore personal recovery in voice hearing from the perspective of the voice hearer. Studies were also included if they did not set out to investigate recovery processes but did relate results to recovery or voice hearers' recovery journey over time; (2) papers that included qualitative data from voice hearers on their perceptions of recovery; (3) studies investigating voice hearing in adolescents and adults (14+ years old); (4) studies where participants were all voice hearers; and (5) studies published in English, peer reviewed and reporting primary data. Exclusion criteria were as follows: (1) studies focused solely on symptom reduction (clinical recovery) as an outcome, (2) studies referring to psychosis or diagnostic labels more broadly, and not specifically discussing voice hearing, (3) research evaluating a specific type of intervention for voice hearers where voice hearers do not relate the outcome to their personal recovery and (4) studies that examined voice hearing experiences in the context of organic disease, post-partum or immediately following illicit drug use.

2.2 | Search strategy

A systemic search was conducted on 11 October 2021 for relevant articles published since the inception of five databases: Applied Social Science Index and Abstracts (ASSIA), CINAHL, MEDLINE, PubMed and PsycINFO. Peer-reviewed, English language studies that focused on voice hearing recovery were included if they were published at the time of searching.

The final search strategy consisted of three parts that reflected the key areas of this review: hearing voices, recovery and the voice hearer's perspective (see Appendix B for a list of search terms). Reference lists of identified papers were also searched to further identify relevant literature and duplicates were removed (see Figure 1 for Preferred Reporting Items for Systematic Reviews and Meta-Analyses [PRISMA] diagram). Eligibility of included papers after full paper reading was decided separately by authors BH and RT. Disagreements were discussed before a decision was made regarding eligibility (see Table 1 for the study summary). Studies were evaluated using the Critical Appraisal Skills Programme (CASP, 2018) tool for qualitative research.

2.3 | Thematic synthesis

This systematic review was guided by the thematic synthesis approach described by Thomas and Harden (2008) to collate available qualitative research. This is achieved by analysing the results of published papers which are coded to determine themes in the data. For this review, full results sections were coded which included participant quotes and authors' explanations. An inductive approach was adopted, being led by the data rather than pre-existing research or frameworks.

Initially, a level of familiarity was attained with included studies. Results sections from the papers were then exported into

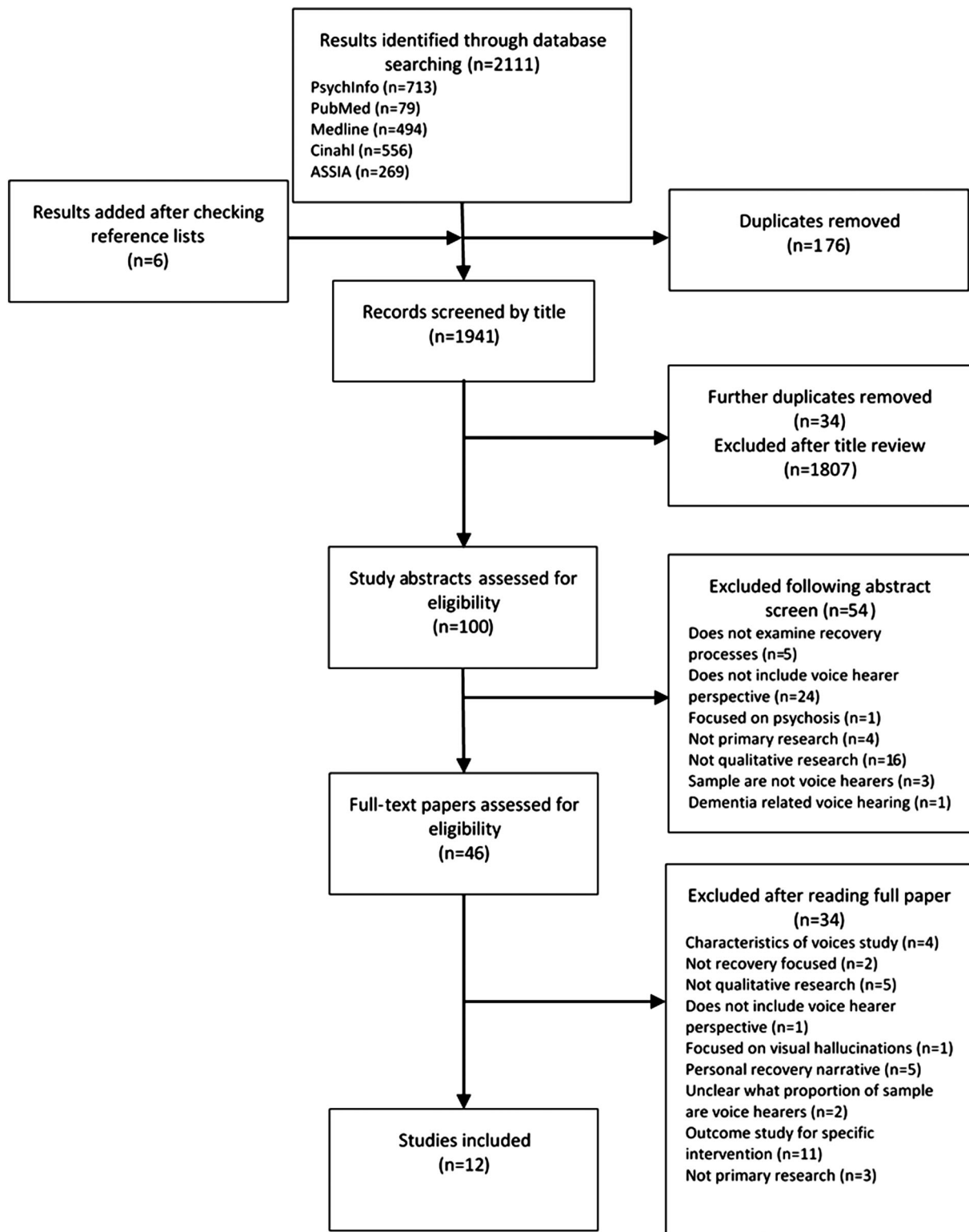


FIGURE 1 PRISMA diagram showing the process of study selection

NVivo (released in 2018) for initial, line-by-line coding. Initial codes were grouped based on the likeness of meaning and content, and descriptive codes were then given to capture overall groupings of initial codes. Following this, themes and subthemes were arrived at through the comparison of descriptive codes. A

subset of data was compared and contrasted with an independent researcher to check inter-rater reliability in coding. The authors also discussed suggested themes to ensure agreement. Frequency and relevance were considered when deciding on final analytic themes.

TABLE 1 Summary of included studies

Study	Author (year)	Participants	Demographics	Context	Design and analysis	Main findings related to recovery
1	Dos Santos and Beavan (2015)	Voice hearers, N = 4	Male = 2, Female = 2, Age early 30s to late 50s, Ethnicity NS, 3/4 schizophrenia, 1/4 bipolar, hearing voices 16 months–40+ years	Recruited from 3 New South Wales HVN groups	Semi-structured interviews Interpretive phenomenological analysis	Group attendance linked to themes of sharing with others, self-esteem, relating to voices and agency beyond the group
2	de Jager et al. (2016)	Voice hearers, N = 11	Male = 4, Female = 7, Age 23–63, 10/11 White, 1/11 Asian, 4/11 schizophrenia, 4/11 schizoaffective, 3/11 psychosis NOS, 5/11 employed, 1/11 student, 3/11 retired, 2/11 disability support pension, 3/11 married, 1/11 divorced, 7/11 single	Recruited from New South Wales HVN and the Australian Schizophrenia Research Bank	Semi-structured interviews Narrative inquiry	Turning away vs. turning towards recovery typologies. Turning away related to distance from voices via medication or distraction. Turning towards linked to personal growth, voice-specific skill and integration
3	Rácz et al. (2017)	Voice hearers, N = 6	Male = 4, Female = 7, Age 31–57, Ethnicity NS	Recruited from Semmelweis University's community psychiatric self-help group for voice hearers in Budapest	Semi-structured interviews Interpretive phenomenological analysis	Four main themes: understanding and accepting voices, improving relationships with voices, peer support from self-help group, the role of the hearing voices method. Hearing voices method linked to communicating with voices, an active role and relationships
4	Clements et al. (2020)	Voice hearers, N = 5	Male = 4, Female = 1, Age 30–62, Ethnicity NS, 3/5 schizophrenia, 1/5 schizoaffective, 1/5 undifferentiated schizophrenia	Recruited from attendees of an HVN group	Semi-structured interviews Interpretive phenomenological analysis	Overarching theme related to tension and recalibration, which permeated five themes: beliefs about voices, relationship with voices, learning to live with voices, rediscovering myself and influences to understanding voices
5	Romme and Morris (2013)	Voice hearers, N = 50	Gender NS, Age NS, Ethnicity NS, 47/50 had received psychiatric care, 26/50 schizophrenia, 5/50 depression, 4/50 dissociative identity disorder, 3/50 borderline disorder, 2/50 manic depression, 7/50 did not clearly report, 3/50 no diagnosis	Recruited through contacts in HVN across 23 countries (mostly European)	Written narrative accounts or semi-structured interviews Analysis method unspecified	Three phases of voice hearing recovery discussed: startling = developing hope and control; organizational = understanding voices and taking back power from voices; stabilization = relationships with voices and others, voice emotional expression
6	Hayward et al. (2015)	Voice hearers, N = 12	Male = 8, Female = 4, Age 20–69, Ethnicity NS, hearing voices for 2–45 years	Recruited via the English and Australian HVN and the British charity MIND	Semi-structured interviews Thematic analysis	Four main themes identified in voice-hearer relationship over time. These were stress, changing experience of voices, valuing conversations (with the voices and others) and different ways of being with the voices

(Continues)

TABLE 1 (Continued)

Study	Author (year)	Participants	Demographics	Context	Design and analysis	Main findings related to recovery
7	Milligan et al. (2013)	Voice hearers, N = 6	Male = 5, Female = 1, Age 17–30, Ethnicity NS, hearing voices for 9–252 months	Recruited from an EIP service in the North of England	Semi-structured interviews Interpretive phenomenological analysis	Six main themes covered participants' voice hearing journey: negative trigger, rejection, crisis-induced change, adjusting and trying to cope, and new understandings
8	Oakland and Berry (2015)	Voice hearers, N = 11	Gender NS, Age 30–60, Ethnicity NS, duration of group attendance 9 months–6 years	Attendees and facilitators from 3 HVN groups in the UK	Semi-structured interviews Thematic analysis	Themes relating to recovery included acceptance, hope and benefits from the group (including talking, learning from others' personal experience and coping beyond the group)
9	Payne et al. (2017)	Voice hearers, N = 8	Male = 4, Female = 4, Age 26–60, 3/8 White British, 1/8 Black British, 1/8 White British Jewish, 2/8 British, 1/8 European, group attendance 2 months–5 years	Attendees from 2 HVN groups in the UK.	Semi-structured interviews Interpretive phenomenological analysis	Themes identified through group attendance were 'healing: connecting with humanity', 'group as an emotional container', 'making sense of the voices and me' and 'freedom to be myself and grow'
10	Ng et al. (2012)	Voice hearers, N = 20	Male = 12, Female = 8, Age 22–55, Ethnicity NS, 20/20 schizophrenia, 20/20 living in half-way houses, 10/20 employed, 10/20 unemployed	Recruited through NGOs providing mental health treatment to people in Hong Kong	Semi-structured interviews Thematic analysis	Results indicated variation in ways of coping, including 'changing social contacts', 'manipulating the voices' and 'changing perception and meaning towards the voices'
11	Bogen-Johnson et al. (2019)	Voice hearers, N = 20 (N = 12 after sample attrition)	Male = 12, Female = 8, Age 19–35, 17/20 White British, 2/20 White Other, 1/20 Mixed Race, 9/20 employed, 1/20 volunteering, 1/20 student, 9/20 unemployed, hearing voices for <1–21 years	Recruited from EIP services in England.	Semi-structured interviews Thematic analysis	'Common Pathway' (antecedents, onset, chaos, responses and change through help) describes shared pathway for voice hearers. While 3 other themes describe divergent pathways: 'Voices Stop', 'Voices Continue but Beliefs Change', 'Voices Continue but Beliefs Do Not Change'. Belief change suggested as important in recovery journey
12	Holt and Tickle (2015)	Voices hearers, N = 8	Gender NS, Age 25–63, 8/8 White British, 5/8 unemployed, 2/8 volunteering, 1/8 not currently working, age at voice onset 3–43, years receiving services 4–22	Recruited within 2 mental health NHS trusts in the UK No other details provided	Semi-structured interviews Grounded theory	Descriptive categories of sense-making were: 'Search for Meaning', 'View of Self', 'Framework for Understanding Voices'. Participants search for meaning of voice hearing, but success of this process is related to perceptions of agency, stigma and hope (lessness)

TABLE 2 CASP review summary table

Paper	Aims	Method	Research design	Sampling	Data collection	Bias and reflexivity	Ethical issues	Data analysis	Findings	Research value
Dos Santos & Beavan (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Yes
de Jager et al. (2016)	Yes	Yes	Yes	No	Yes	Yes	Yes	Partially	Yes	Yes
Rácz et al. (2017)	Yes	Yes	Yes	Partially	Partially	Cannot tell	Partially	Partially	Partially	Partially
Clements et al. (2020)	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes
Romme and Morris (2013)	Yes	Yes	Cannot tell	Partially	Partially	Cannot tell	Partially	Cannot tell	Partially	Partially
Hayward et al. (2015)	Yes	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Yes	Yes
Milligan et al. (2013)	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes
Oakland and Berry (2015)	Yes	Yes	Partially	Yes	Partially	Yes	Yes	Partially	Yes	Yes
Payne et al. (2017)	Yes	Yes	Yes	Yes	Partially	No	Partially	Yes	Yes	Yes
Ng et al. (2012)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Cannot tell	Partially	Partially
Bogen-Johnson et al. (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes
Holt and Tickle (2015)	Yes	Yes	Yes	Cannot tell	Partially	Cannot tell	Partially	Partially	Yes	Yes

Note: The CASP is a qualitative research appraisal tool designed to evaluate studies across 10 key areas: clear statement of aims, appropriateness of qualitative methods, appropriate research design, appropriate sampling strategy, appropriate data collection to address research issue, consideration of bias, consideration of ethical issues, appropriate data analysis, clear statement of findings and overall value of research. See the CASP for further detail on how this is assessed: <https://casp-uk.net/casp-tools-checklists/>

3 | RESULTS

3.1 | Quality of review articles

The CASP (2018) checklist for qualitative research was used. Results of the 10-item tool are displayed in Table 2. Studies were rated by the author and an independent researcher, with high concordance. Disagreements were discussed until a rating was agreed upon. All studies were of adequate quality for inclusion. Items of the CASP have been grouped together here and only the main evaluative points will be discussed for succinctness.

3.2 | Research aims, methods and design

Qualitative methodologies were appropriately selected for all studies. Various approaches were used across the studies, including interpretive phenomenological analysis (Clements et al., 2020; Dos Santos & Beavan, 2015; Milligan et al., 2013; Payne et al., 2017; Rácz et al., 2017), thematic analysis (Bogen-Johnson et al., 2019; Hayward et al., 2015; Ng et al., 2012; Oakland & Berry, 2015), narrative analysis (de Jager et al., 2016) and social constructionist grounded theory (Holt & Tickle, 2015). One study did not report how they analysed data (Romme & Morris, 2013), meaning the procedure by which the

authors arrived at their conclusions is unclear and casts doubt on the rigour of this research.

3.3 | Sampling

Two studies required participants to have currently heard voices (Bogen-Johnson et al., 2019; Dos Santos & Beavan, 2015), which could have impacted on the results, whereas the remainder did not stipulate or allowed for historic voice hearing. Two papers reported how either clinicians (Clements et al., 2020) or contacts within the same research field (Romme & Morris, 2013) identified participants, and no studies reported reasons for non-participation, potentially introducing bias into the research. It is possible that voice hearers with varied or more distressing experiences of recovery were less likely to take part.

Several studies did not report certain demographic information such as gender (Holt & Tickle, 2015; Oakland & Berry, 2015; Romme & Morris, 2013) and ethnicity (Clements et al., 2020; Dos Santos & Beavan, 2015; Hayward et al., 2015; Milligan et al., 2013; Ng et al., 2012; Oakland & Berry, 2015; Rácz et al., 2017; Romme & Morris, 2013), influencing the conclusions that can be drawn with relevant socio-cultural influences. Of the studies that reported on ethnicity, samples were predominantly of White ethnicity suggesting that

TABLE 3 A summary of recovery superordinate and subordinate themes

Recovery phases	N	Recovery facilitators	N	Barriers to recovery	N
Adverse experiences and stress	6	Supportive mental health services and engaging with HVN	12	Mental health services as disempowering and unhelpful	9
Voice onset: Fear, bewilderment and shame	10	Making sense of experiences	12	Negative impact of voices	5
Overwhelmed by voices	9	Changing beliefs and relationship with voices	11	Social isolation	6
Attempting to cope and reaching out	10	Connection with others and the outside world	11	Stigmatized identity	12
Differing responses to change	11	Empowerment	11		
Integration of voices & (re) developing self	11				

results may be limited given the diverse experiences of recovery and varying pressures facing people from different ethnic backgrounds (Morgan et al., 2017).

3.4 | Data collection, bias and ethical issues

While several studies provided adequate descriptions of interview questions (Hayward et al., 2015; Ng et al., 2012; Oakland & Berry, 2015; Romme & Morris, 2013), the remaining studies provided either only some examples of questions or no indication of the interview schedule used. This limits the transparency of the research and makes it hard to determine whether bias influenced data collection. Studies discussing data saturation (Bogen-Johnson et al., 2019; Hayward et al., 2015; Oakland & Berry, 2015) or sufficiency (Milligan et al., 2013) are in the minority, suggesting that it is unclear to what extent results from other papers are adequately defined and capture the experiences of voice hearers.

3.5 | Data analysis, findings and research value

In terms of data analysis, all but three studies included detailed descriptions of the analytic procedure (Ng et al., 2012; Rác et al., 2017; Romme & Morris, 2013), and of these, only Rác and colleagues discussed how themes were derived from the data. The analytic rigour applied to these studies is therefore unclear. For six papers, the researcher's role and potential bias within qualitative analysis were thoroughly considered; however, in the remaining papers, this could have been expanded upon (Holt & Tickle, 2015; Ng et al., 2012; Oakland & Berry, 2015; Payne et al., 2017; Rác et al., 2017; Romme & Morris, 2013). Findings in these studies should therefore be interpreted with caution.

3.5.1 | Thematic synthesis

Thematic synthesis resulted in the generation of three superordinate themes: 'Recovery Phases', 'Recovery Facilitators' and

'Barriers to Recovery' (see Table 3 for the summary). The theme 'Recovery Phases' captured the reported experiences voice hearers navigated along the journey towards recovery. 'Recovery Facilitators' and 'Barriers to Recovery' highlight the factors that respectively help or hinder recovery processes. Results will be described with verbatim quotes, of which, the most pertinent were selected for inclusion.

3.6 | Recovery phases

This superordinate theme was found across all studies ($n = 12$). The characteristics of voice hearers' recovery were described as a personal process. The recovery journey was also thought of as iterative, non-linear and ongoing. Six subthemes were identified which related to recovery phases of voice hearing.

3.6.1 | Adverse experiences and stress

Six studies discussed challenges participants faced earlier in their lives or more recent stressors (Bogen-Johnson et al., 2019; de Jager et al., 2016; Hayward et al., 2015; Holt & Tickle, 2015; Milligan et al., 2013; Romme & Morris, 2013). The below captures some of the common adversities reported:

18 voice-hearers related their voices to their sexual abuse; 11 related them to their emotional abuse; 6 to intense adolescent problems; 4 to high levels of stress; 2 to being bullied; 2 to their physical abuse. (Author; Romme & Morris, 2013, p. 264)

Acute stressors were also discussed, and participants spoke of these as antecedents to voice hearing.

I had a very difficult night having the panic attacks and it was dark, and I think that probably, was the beginning of the tipping point into voice hearing. (Participant; Hayward et al., 2015, p. 100)

3.6.2 | Voice onset: Fear, bewilderment and shame

This subtheme captured the beginning of voice hearing and the reaction it provoked in participants, discussed in 10 papers (Bogen-Johnson et al., 2019; Clements et al., 2020; De Jager et al., 2016; Dos Santos & Beavan, 2015; Hayward et al., 2015; Milligan et al., 2013; Ng et al., 2012; Oakland & Berry, 2015; Payne et al., 2017; Rácz et al., 2017). This reaction was often characterized by fear of voices initially:

I was scared ... It was new to me, the whole idea of hearing voices, and I was a little bit petrified that I was going mad. (Participant; Clements et al., 2020, p. 200)

Some studies spoke of participants not knowing anyone else who had heard voices, and so this was a completely new experience for them. At this stage, general feelings of bewilderment and a deep sense of shame were discussed across several studies, which often lead to a secrecy around voice hearing.

... when I first started hearing the voices, I felt, I didn't feel I could really tell people. I felt quite ashamed and, as if there was something wrong with me. (Participant; Payne et al., 2017, p. 211)

3.6.3 | Overwhelmed by voices

Papers that contributed to this subtheme discussed how voices became overwhelming and overpowering for participants, worsening since initial onset (Bogen-Johnson et al., 2019; Clements et al., 2020; De Jager et al., 2016; Hayward et al., 2015; Holt & Tickle, 2015; Milligan et al., 2013; Ng et al., 2012; Rácz et al., 2017; Romme & Morris, 2013). Voices were often seen as separate, external to participants and able to exert control over them.

When voices were dominating, participants felt 'plagued' (Alex) or 'overwhelmed' (Ella). (Author; Clements et al., 2020, p. 201)

Papers described how these experiences reduced participants' sense of control, increased distress and lead to feelings of hopelessness and fatigue.

Subsequent experiences had a sense of 'chaos' as voices increased in frequency and confusion and distress escalated. (Author; Bogen-Johnson et al., 2019, p. 312)

3.6.4 | Attempting to cope and reaching out

This phase captures how voice hearers responded to increasing distress levels across all except two studies (Holt & Tickle, 2015; Rácz

et al., 2017). Coping strategies were beginning to be experimented with; however, these could be ineffective or unhelpful ways of managing or were not consistently relied on.

Participants described trying everything they could think of to improve their situation, to no avail. (Author; de Jager et al., 2016, p. 1413)

Several papers mentioned participants' disclosure of voice hearing to others, which could be professionals, family members or fellow voice hearers. For two papers (Bogen-Johnson et al., 2019; Milligan et al., 2013), this communication was an outcome of participants reaching a crisis point that necessitated additional support. Following disclosure, family members or professionals could encourage access to other potentially beneficial resources, such as mental health services or Hearing Voices Network (HVN) groups.

... all informants finding the group through another person, either a loved one or via their current mental health professionals. (Author; Dos Santos & Beavan, 2015, p. 30)

3.6.5 | Differing responses to change

All except one study (Oakland & Berry, 2015) referred to the ways in which participants responded to voice hearing following overwhelming experiences, crises or disclosure. Two main responses were identified: searching for the meaning of voices or seeking distance from voices. Searching for meaning related to participants who strived to understand their voices. This response involved acknowledgement and a belief there was an underlying meaning or purpose to their experience.

I prayed ... deeply as to what was my purpose, what was the point of having a mental illness? (Participant; de Jager et al., 2016, p. 1413)

Alternatively, most papers reported on a different response, one that sought distance from voices. Attempting to block out voices and fighting with them were examples of how this was attempted.

I do scream at the voices, I quite often in the morning when they're having a go at me. (Participant; Hayward et al., 2015, p. 103)

As opposed to searching for meaning, seeking distance was associated with a fixed understanding of voice hearing and could result in continued distress. This occurred for participants believing voice hearing to be a meaningless experience, having little interest in understanding it or continuing to see voices as an illness either because of the benefits of the medical model or because they were told this by professionals.

An explanation of the voices was not seen by all participants as being valuable, which could in itself be a potential blocking factor. (Author; Holt & Tickle, 2015, p. 259)

3.6.6 | Integration of voices and (re)developing self

Integration of voices described the phase whereby voices came to be less distressing or disruptive. For participants who continued to hear voices, seeing voices as part of oneself or one's life and having ways of effectively managing were associated with this phase, as opposed to aiming for voices to go away.

With the new meaning towards the voices, they might consider the voices as a part of themselves and of their lives and could feel more in control of the voices. (Author; Ng et al., 2012, p. 5)

For participants whose voices had stopped, there was a sense of relief but concern remained about voices returning. Voices stopping was attributed to medication and professional support and could lead to further consideration on the significance of the experience.

They discussed their fears of voices returning as well as thoughts (which were mixed) on how the experience had changed them. (Author; Bogen-Johnson et al., 2019, p. 313)

Most papers that contributed to this subtheme described participants building upon their sense of self once distress had reduced. Several papers (Bogen-Johnson et al., 2019; Clements et al., 2020; Payne et al., 2017) discussed how personal growth was attributed to the experience of voice hearing at this stage, which seemed possible to occur whether voices continued or not.

The experience has very much helped to understand myself and find my voice. (Participant; Clements et al., 2020, p. 201)

Improvements in self-esteem, being able to live a more meaningful life, recognizing and accepting emotions and oneself and developing identity were all experiences that occurred during this phase, contributing to the process of recovery.

3.7 | Recovery facilitators

'Recovery Facilitators' were factors that supported recovery processes, featuring in all papers.

3.7.1 | Supportive mental health services and engaging with HVN

All papers described how accessing supportive mental health services or engaging with HVN groups facilitated recovery. Mental health services, when holistic and attuned to voice hearers, provided participants with a general sense of being supported, which some described as being quite novel following disclosure of voices. Professionals who listened to individuals and supported them to find ways of coping with voices were appreciated, as were psychological interventions.

Some participants indicated that therapy, either through psychological interventions or the support of EIP [Early Intervention in Psychosis] team members, bettered their ability to cope with their voices or helped their self-confidence. (Author; Milligan et al., 2013, p. 114)

Starting medication could also be helpful to participants' recovery, leading to increased confidence in daily life and improved functioning. HVN groups were another source of support for participants. The various benefits of attending the group included feeling supported by group members, having a sense of connection, learning coping strategies from others and sharing life stories. Studies described how these groups perhaps offered something different to mental health services, as they fostered experiences of personal growth, did not adopt an illness model of voice hearing and actively promoted the possibility of recovery.

Observing others' abilities to deal with their experiences helped group participants to believe that recovery was possible. (Author; Oakland & Berry, 2015, p. 124)

3.7.2 | Making sense of experiences

Making sense of experiences was the process whereby meaning was beginning to or had been attributed to voice hearing. This was described in all papers and further facilitated recovery. Studies discussed how sense-making lead to participants' changing understanding of voices, making links to previous adversity and conceptualizing their voices under different explanatory frameworks, such as relating to spirituality. This could occur through self-reflection, psychological therapy or HVN groups.

I have an understanding of what my voices are and where they come from and as I've been able to cope with them better, and as I've got better in myself and they've reduced then that's made life a lot better. (Participant; Payne et al., 2017, p. 211)

This facilitator served the function of normalizing voices within the context of individuals' lives and reduced distressed. There was also some mention of individuals having a greater insight into the experience, finding voices more familiar and predictable.

... participants became acutely aware that their voices were likely to become problematic during times of heightened anxiety and vice versa, thus becoming a 'litmus test' for psychological well-being. (Author; de Jager et al., 2016, p. 1415)

3.7.3 | Changing beliefs and relationships with the voices

Bar one study (Payne et al., 2017), all papers included results related to changes in beliefs or relationships with voices. Changing beliefs about voices, most commonly beliefs about voice truthfulness, power and control, appeared linked to recovery. Reappraisal of voice power could occur within psychological therapy, or some participants shared their self-directed attempts to challenge voices. Accounts reflected a changing relationship with voices in line with changing beliefs, such as shifts in perceptions of relative power.

I just feel like that my life is not controlled by my voice anymore. It's controlled by what I want to do and then the voice is secondary. (Participant; Bogen-Johnson et al., 2019, p. 314)

Participants also attempted to communicate and engage with voices in a different manner. This could be driven by a desire to better manage or to understand their intentions.

I'll say 'I acknowledge you, I understand you're there, please give me two hours and we'll speak again in two hours' time'. (Participant; Clements et al., 2020, p. 201)

Some studies discussed participants accepting the voices and their existence, which seemed to reduce tension and stress of the individual. Although not possible for all, forming a more harmonious relationship could occur where voice hearers and voices could communicate with minimal conflict.

3.7.4 | Connection with others and the outside world

Except for Clements et al. (2020), all papers contributed to this sub-theme, which related to having a renewed sense of connection with other people and the world. This involved spending more time with loved ones, relating to fellow voice hearers, feeling accepted by others and being able to talk about their experiences of voice hearing and

find benefit in this. HVN groups could be a safe space for connections between voice hearers to occur.

I felt like I belonged somewhere so I could take my mask off and feel safe. (Participant; Oakland & Berry, 2015, p. 124)

Meaningful activity was a means for voice hearers to connect to the outside world and have a purpose, which was often described as an interpersonal process.

Participants felt more valued by themselves and others when they were able to contribute to others: 'It makes me feel as though I'm contributing to something'. (Participant; de Jager et al., 2016, p. 1416)

3.7.5 | Empowerment

This refers to descriptions of an empowered-self, greater feelings of autonomy and an ability to face problems. This was described in all except one study (Milligan et al., 2013) and was associated with reduced fear of voices.

It's changed my understanding of myself really because yes, I believe, it's one of those things, I believe I'm stronger than I was because of the experience I've been through. (Participant; Bogen-Johnson et al., 2019, p. 313)

3.8 | Barriers to recovery

The final theme, featured in all 12 papers, encompassed experiences that acted as barriers to recovery for voice hearers. While consisting of fewer subthemes and codes, experiences captured here were particularly poignant and could occur at any phase of recovery.

3.8.1 | Mental health services as disempowering and unhelpful

Featuring in nine studies (Bogen-Johnson et al., 2019; Clements et al., 2020; De Jager et al., 2016; Hayward et al., 2015; Holt & Tickle, 2015; Milligan et al., 2013; Ng et al., 2012; Oakland & Berry, 2015; Romme & Morris, 2013), mental health services could act as barriers to the recovery journey through interventions intending to support voice hearers being unhelpful or ineffective, leading to a sense of hopelessness.

They gave me some medicine and told me it would get rid of it, but they only just kept getting worse and

worse and worse. (Participant; de Jager et al., 2016, p. 1412)

Disclosure to professionals was a risk for voice hearers, which they feared could result in them being placed in 'an asylum'. Alternatively, examples were captured whereby professionals refuted voice hearers' experience and the sense they made of it, invalidating and disempowering participants.

participants described how pathological discourses of voice hearing from mental health clinicians invalidated their perspectives, gave them little hope for recovery and negatively influenced their identity. (Author; Clements et al., 2020, p. 202)

3.8.2 | Negative impacts of voices

Voices in and of themselves constituted a barrier to recovery. Four studies (Bogen-Johnson et al., 2019; Holt & Tickle, 2015; Milligan et al., 2013; Ng et al., 2012) highlighted how voices tended to worsen again and become more distressing at times of heightened affect. This could prove to be a maintaining factor for distressing voices and mood difficulties, forming a vicious circle for some participants.

I get paranoid and the voices contribute to the paranoia and the paranoia will get out of control and that's when the depression will set in from the paranoia. (Participant; Milligan et al., 2013, p. 111)

Fluctuating voice hearing activity and conflict in the voice–voice hearer relationship could also negatively impact on recovery processes.

What they do is wicked and it's horrible and I think making someone feel that vulnerable and that down, no I would never wanna have a relationship with someone like that. (Participant; Hayward et al., 2015, p. 101)

3.8.3 | Social isolation

Only six studies contributed to this subtheme (Clements et al., 2020; de Jager et al., 2016; Dos Santos & Beavan, 2015; Milligan et al., 2013; Payne et al., 2017; Rácz et al., 2017); however, social isolation could form a significant barrier for individuals. Voices were regularly named as a cause of isolation and perpetuated feelings of disconnection from others for participants.

I was so isolated because of the voices I think that I never really spoke to anyone. (Participant; Dos Santos & Beavan, 2015, p. 31)

Isolation permeated various relationships for voice hearers, including distance from their family, from fellow HVN group members and from the world generally.

I had problems, and because of that I didn't have a harmonic relationship with the outside world. (Participant; Rácz et al., 2017, p. 310)

3.8.4 | Stigmatized identity

Stigmatized identity was the most prominent recovery barrier, present in all papers. Data coded to this theme discussed the negative impact of stigma on the recovery process, which included blatant prejudice, people having negative responses to voices or participants fearing judgement from others.

Ella commented that it was often difficult to resist assuming the 'societal ... archetype of the crazy one. The insane person who is, by definition, defective and inferior'. (Author/Participant; Clements et al., 2020, p. 202)

When negative perceptions of voice hearing and emotional distress were internalized by participants in the studies, this could lead to diminished self-esteem and poor self-identity.

How could I contribute (to society) if I had this prognosis? I think my self-esteem and everything was the lowest it could be. (Participant; de Jager et al., 2016, p. 1413)

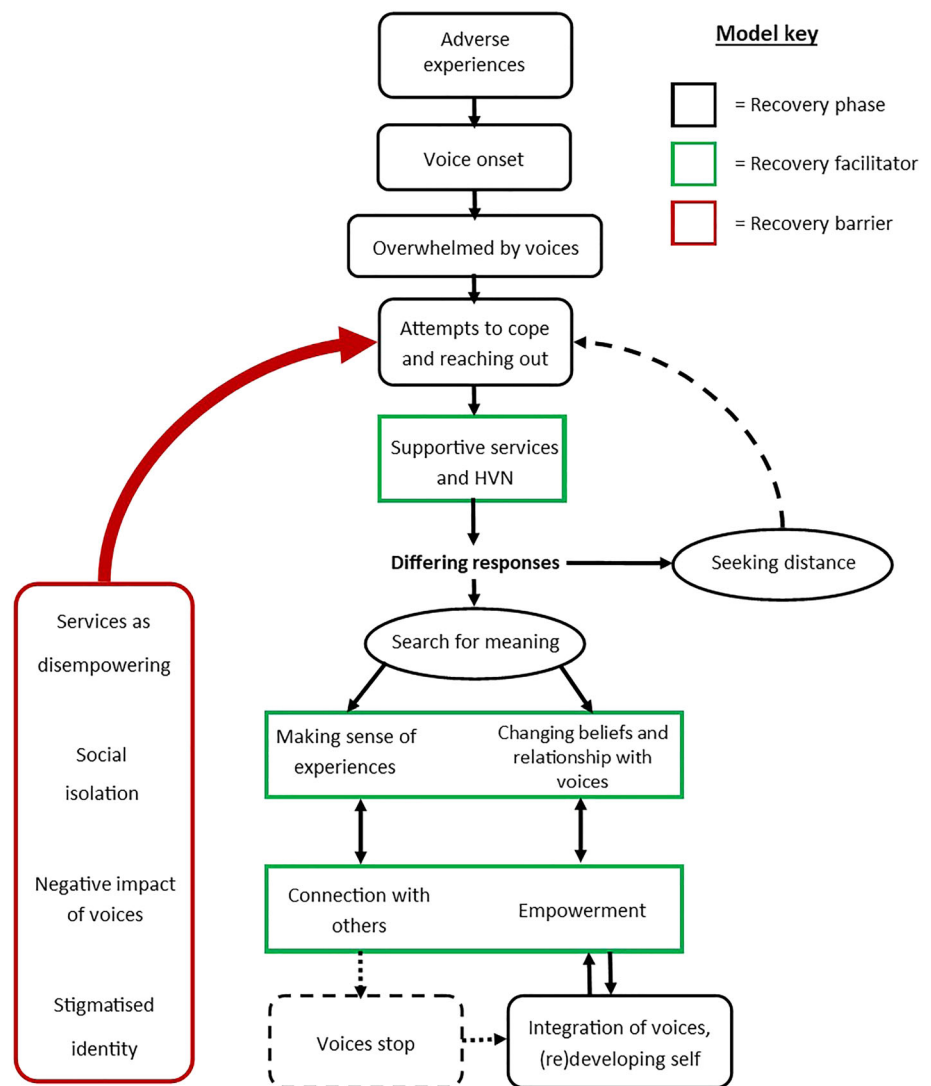
3.9 | Synthesizing a recovery model

Themes and subthemes emerging from the thematic synthesis have been integrated and are represented in Figure 2.

4 | DISCUSSION

This review intended to systematically review and use thematic synthesis to integrate current literature on personal recovery in voice hearing. The results suggest six phases voice hearers may experience denoting the journey of recovery: 'Adverse Experiences and Stress', 'Voice Onset', 'Overwhelmed by Voices', 'Attempts to Cope and Reaching Out', 'Differing Responses to Change' and 'Integration Of Voices & Developing Self'. Five facilitators and four barriers to recovery phases were identified and are integrated within a proposed model of personal recovery and voice hearing. Recovery was perceived to be ongoing and personal, and while phases are described, ways in which these were achieved and related outcomes were idiosyncratic for participants across studies.

FIGURE 2 Synthesis of themes and subthemes into a diagrammatic model of voice hearing recovery [Colour figure can be viewed at wileyonlinelibrary.com]



4.1 | Recovery phases and voice hearing

The findings that emerged within the theme 'Recovery Phases' largely map onto the initial model proposed by Romme and Escher (1989) and later expanded upon to combine the experiences of people who hear voices within clinical services (Milligan et al., 2013). The preceding adversity, onset of voices and attempts to cope as found in this review, support experiences described within the 'Startling Phase'. Confusion and anxiety were feelings described at this time, but more poignant emotions of fear and shame associated with voice onset were also identified, which have previously been implicated in voice hearing (Carden et al., 2020) and are consistent with increased prevalence of traumatic events among this population (Corstens & Longden, 2013). The 'Organisation Phase', from Romme and Escher's model, is a time for testing coping and examining meaning, and in this review, making sense of voices was a facilitative process that was reported to reduce distress. This corroborates previous research and the value of sense making for voice hearers, which has been advocated for by members of HVN (Longden, 2010). Processes of

connecting with other voice hearers and regaining power from voices were also apparent in the review findings. Lastly, the 'Stabilisation' phase from Romme and Escher and the final phase of this model share some common features, namely, accepting voices and improvements in relationships with voices. While a more balanced relationship with voices was indicative of the final phase of the outlined model, the process of changing relationships with voices was a facilitating factor and seemed to be important for integrating voices.

4.2 | Understanding voices

Previous cognitive models of voice hearing have suggested schemata surrounding voices, the self and social standing predict appraisals, associated distress and responses (Chadwick & Birchwood, 1994; Morrison, 2001). Within cognitive theory and cognitive behavioural therapy for distressing voices, beliefs are thus of central importance. Belief change has been further indicated in recovery and voice hearing and was reported as determining the recovery pathway in one of the

included studies (Bogen-Johnson et al., 2019). While identified as supporting recovery in this review, belief change was not found to be as significant as previously suggested. Instead, a pivotal process along the recovery pathway seemed to be whether initial support-seeking resulted in a search for meaning or a desire for distance regarding voices. These processes map onto the concepts of 'sealing over' and 'integration' psychosis recovery patterns as identified by McGlashan et al. (1975). Advocates from within the hearing voices movement have attested to the importance of understanding voices, making sense of experiences and the pertinence of this to personal recovery (Corstens et al., 2014). Distance-creating patterns of responding to voices, such as attempts to block out voices, are reportedly associated with experiencing distressing voice hearing (Sayer et al., 2000) and may have featured in this review due to the inclusion of literature on clinical populations who tend to report higher levels of distress and distressing voice content (Beavan & Read, 2010). However, while studies varied in their reporting of whether participants currently heard voices, no specific patterns in results were found for the two studies which did, suggesting that the ongoing experience of hearing voices may not have a significant impact on other aspects of the recovery journey.

4.3 | Interpersonal recovery processes

The recovery phases depicted in this review are largely self-directed; however, the facilitators mostly relate to changes in the understanding of the self and others. In contrast, the barriers identified speak to broader level social and environmental factors. Findings suggest that negative interpersonal experiences and functioning hinder the processes of recovery. Mentalization theory offers a framework to understand this by suggesting that maladaptive social and cognitive factors limit the capacity for mentalization, the ability to interpret behaviour and understand relevant mental states such as thoughts, feelings, needs and wishes (Bateman & Fonagy, 2004). As also highlighted in this review, literature on mentalization notes the links between earlier childhood trauma and adversity and posits that these experiences are likely to impact on the development of secure attachments and disrupt the child's ability to mentalize (Weijers, Ten Kate, Debbané, et al., 2020). Thus, mentalization and metacognitive approaches may understand supportive interpersonal factors to be enabling a greater sense of self and others, whereas the environmental barriers in this review may inhibit these processes (Lysaker et al., 2018).

Several facilitators were found that related to study descriptions of interpersonal relationships. Literature focused on people with first-episode psychosis has found there to be significant barriers to individuals seeking help (Anderson et al., 2013). The importance of loved ones initiating help-seeking processes was emphasized within this review, similar to Anderson et al.' (2013) findings. Psychosis research has also identified related recovery themes regarding the role of others, with social support, isolation and stigma all previously being implicated in recovery from psychosis (Wood & Alsawy, 2018). While that research was focused on psychosis populations and this review is

related to voice hearing specifically, there may be some shared recovery processes across populations. Indeed, Leamy et al.'s (2011) work summarizing recovery into the CHIME model does seem to relate to many of the themes captured within this review. The current review did, however, find specific processes relating to recovery in voice hearing, which included more challenging experiences that do not feature in the CHIME model (Stuart et al., 2017). Stigma, for example, appeared across all included papers and could be a significant barrier to recovery in voice hearing. Within many Western societies, voice hearing stigma is pervasive and can impact on individuals' functioning and wellbeing (Yanos et al., 2008), so it is perhaps understandable this constituted a recovery barrier.

While there may be similarities between recovery processes implicated in voice hearing and psychosis, understanding any differences in the process of recovery for people with these experiences is vital. One noteworthy comparison between the phases discussed within this study and that of the wider literature on psychosis and schizophrenia recovery is the role of family within recovery. In this study, family could be an important enabler in help-seeking; however, the role of family in ongoing recovery was less implicated than it has been in psychosis research (Jose et al., 2015; Waller et al., 2019). One explanation for this may be that voice hearers within the included studies instead sought social connection with other people who hear voices. There also appeared to be less focus on the 'symptom' cessation within the results of this study compared with psychosis literature. Previous studies have defined recovery in psychosis as occurring with or without ongoing symptoms; however, for some with lived experience of psychosis, it is clearly important for anomalous experiences to cease to occur (Jose et al., 2015). Within the included studies, voice hearers focused on learning how to cope with the experience instead of pursuing being symptom-free. Furthermore, the phases of voice hearing discussed here differentiate from psychosis stages of recovery whereby the beginning of anomalous experiences is preceded by heightened intensity and distress, attempts to cope and help-seeking, before these experiences can be 'integrated' (Wood & Alsawy, 2018). The later phases of the model also situate the way voice hearers respond to and integrate voices within an ongoing relationship, as opposed to the literature on psychosis and recovery, which tends to discuss an episode of psychosis as an event (Nixon et al., 2010). These experience-specific aspects of voice hearing suggest that recovery in voice hearers can be understood somewhat differently from that of psychosis more broadly, which may have implications for how loved ones, services and organizations support voice hearers.

Supportive services and HVN groups emerged as recovery-enabling experiences in this review, with some speaking of the benefits of medication, others of psychological therapy and connecting with other voice hearers. Generally, taking a supportive and hopeful stance that listened to the need and preferences of participants seemed to be the underlying significance of this subtheme. When this occurred, it appeared to have a further enabling effect on other facilitators such as changing beliefs and relationships with voices, sense making and empowerment, which is supported by literature evaluating

therapeutic change processes for voice hearers (Hall et al., 2022). There have been calls for services to offer interventions that are tailored to the subjective meaning of voices (Loneragan, 2017), and HVN groups advocate for the sharing of stories and mutual respect for individuals' explanatory framework (Dillon & Hornstein, 2013). Mentalization-based therapy that supports voice hearers to develop meaningful narratives about their experiences and potentially rebuild connections with others may also play a role here (Weijers, Ten Kate, Viechtbauer, et al., 2020). Conversely, services were viewed as disempowering when participants' meaning was not considered or support was inadequate, corroborating existing literature (Coffey & Hewitt, 2008). The suggested model depicted the ongoing nature of recovery in voice hearers, and although this model proposes a final phase, this does not denote a cessation of recovery processes. This finding bears resemblance to psychosis literature pointing to continuing management of challenges that arise when in recovery (Dilks et al., 2010; Dixon et al., 2010).

4.4 | Limitations

This is the first time that results from across qualitative studies have been combined to elucidate personal recovery processes in voice hearing. Outcome studies were excluded from this review if processes were not associated with recovery by participants. Though this ensured recovery was defined by voice hearers themselves, this may have limited the available literature on the ways in which services and therapeutic interventions enable recovery in voice hearing. Existing grey literature was not considered in this research. While not going through a peer review process and potentially being harder to access, grey literature may have provided alternative information outside of the academic domain.

The results of this review are also limited given recovery is a personal process that varies across cultures (Tse & Ng, 2014), and participants in the included studies mostly identified as White or their ethnicity was not reported. This review utilized the a priori definition of adolescence to be between the ages of 14–19 years old; however, the World Health Organization suggests adolescents to be between the ages of 10 and 19 (WHO, 2014). This would have excluded voice hearers in early adolescence, a limitation of this review and an area for future study. While the inclusion criteria sought to include adolescent and adult voice hearers, no studies were found that examined voice hearing recovery in people under the age of 17. Therefore, the recovery process of voice hearing could vary across ages, and the processes included in this study may not be relevant to younger voice hearer populations.

Finally, there were no studies included in this review that examined the journey of voice hearers whose voices are positive or encouraging, which is a documented phenomenon in the literature (Sanjuan et al., 2004). This review attempted to be inclusive of various voice hearing experiences and included research with clinical and non-clinical populations; however, participant accounts tended to refer to distressing rather than positive voice hearing. Therefore, it is unclear

whether the model reflects the journey of people who only hear positive or neutral voices, or indeed, whether ideas around recovery are relevant to this group.

4.5 | Implications

From the synthesized studies, it was apparent that individuals' journey of recovery was perceived to have started before the onset of voices and was associated with adversity and stress. At a population level, practices may be adopted in health and social care and wider organizations that seek to mitigate acute levels of stress experienced by individuals that have already experience adversity, such as trauma-informed care (Fallot & Harris, 2008). This may also include resources for managing emotional wellbeing being widely shared to support individuals before any need for clinical services, for example, self-help coping strategy resources. Given the role of shame, fear and stigma in blocking help-seeking and stalling recovery journeys, attempts should be made to destigmatize and normalize the experience of voice hearing in the UK. This is especially important within healthcare, but also institutions like the media, which may perpetuate harmful narratives of voice hearers being violent or criminals (Vilhauer, 2015).

Early recovery experiences of individuals suggested attempts to reach out to access support. Within primary care and mental health settings, professionals should have the ability and confidence to scaffold helpful conversations about voices that lead to appropriate support. This might require further training given the obstacles in talking about voices, such as clinician attitudes (Bogen-Johnston et al., 2020; Coffey & Hewitt, 2008). The results of this review also point to the importance of social activity. The standards expected of Early Intervention in Psychosis teams' social recovery programmes relate to several themes identified in this review, such as promoting connection with others, combatting isolation and engaging in meaningful activity (Royal College of Psychiatrists, 2018). Resources should be made available for this to be offered in all services that support people who hear voices. Equally, mental health teams may benefit from a transdiagnostic view of voice hearing (Hazell et al., 2018) and should endeavour to ask the question 'how best can individuals who hear voices be supported and empowered irrespective of their diagnosis?'

The search for meaning pathway within this model appeared to relate to more significant recovery processes for voice hearers in the included studies. Clinical services should continue to promote psychological interventions with an aim to explore individual's sense making. The Maastricht interview, developed by Romme and Escher (2000), may hold promise in supporting voice hearers to make sense of the seemingly bewildering experiences; however, further evaluation of this technique is still needed (Steel et al., 2019). A collaborative approach between services and HVN is also likely to further facilitate voice hearers' recovery, and services should seek to link individuals in HVN groups where appropriate (Styron et al., 2017).

4.6 | Future research

Future research should endeavour to utilize longitudinal research designs to discern recovery factors at various stages of voice hearing. In particular, barriers to recovery were not as well defined in this review and should be an area of future investigation. Another possible avenue of further study would be understanding if there were any kinds of support that voice hearers would appreciate early on in their journey with voices, for example, soon after voice onset or when voices become overwhelming. This type of study would help elucidate forms of support for voice hearers earlier and to understand why some voice hearers experience clinical levels of distress while others do not. The inclusion of quantitative and qualitative data may add to future reviews.

5 | CONCLUSION

This review sought to review and synthesize current qualitative literature on recovery and voice hearing from the perspective of people who hear voices. Recovery was a highly individual process; however, phases of recovery are suggested within a model whereby voice hearers move from being distressed and overwhelmed by voices to accepting voices and developing a positive self-identity. Previous literature suggests that voice hearers may adopt either a stance that seeks meaning or seeks distance in their relationship with voices and seems predictive of recovery pathways. Facilitators and barriers of recovery were identified as key themes across the voice hearing recovery literature and have been synthesized within a model of recovery in voice hearing, building upon previous work. Future studies should further investigate the applicability of the suggested model to both samples of clinical and non-clinical voice hearers using empirical methods. Psychological interventions for voice hearing were also noted to support key recovery-facilitating processes. Examining the change processes involved in interventions for voice hearing and how positive change is supported would be an avenue for further study, as this may too support recovery in voice hearing.

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CONFLICTS OF INTEREST

There are no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not possible with this review as the data consisted of results sections of other published papers and as such are subject to copyright restrictions.

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REFERENCES

- Alyahya, N. M., Munro, I., & Moss, C. (2022). The experience of psychosis and recovery from consumers' perspectives: An integrative literature review. *Journal of Psychiatric and Mental Health Nursing*, 29(1), 99–115. <https://doi.org/10.1111/jpm.12696>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). APA. <https://doi.org/10.1176/appi.books.9780890425596>
- Anderson, K. K., Fuhrer, R., & Malla, A. K. (2013). "There are too many steps before you get to where you need to be": Help-seeking by patients with first-episode psychosis. *Journal of Mental Health*, 22(4), 384–395. <https://doi.org/10.3109/09638237.2012.705922>
- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *The Australian and New Zealand Journal of Psychiatry*, 37(5), 586–594. <https://doi.org/10.1046/j.1440-1614.2003.01234.x>
- Bateman, A. W., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders*, 18(1), 36–51. <https://doi.org/10.1521/pedi.18.1.36.32772>
- Beavan, V. (2011). Towards a definition of "hearing voices": A phenomenological approach. *Psychosis*, 3, 63–73. <https://doi.org/10.1080/17522431003615622>
- Beavan, V., & Read, J. (2010). Hearing voices and listening to what they say: The importance of voice content in understanding and working with distressing voices. *The Journal of Nervous and Mental Disease*, 198(3), 201–205. <https://doi.org/10.1097/NMD.0b013e3181d14612>
- Birchwood, M., & Chadwick, P. (1997). The omnipotence of voices: Testing the validity of cognitive model. *Psychological Medicine*, 27(6), S0033291797005552. <https://doi.org/10.1017/S0033291797005552>
- Birchwood, M., Gilbert, P., Gilbert, J., Trower, P., Meaden, A., Hay, J., Murray, E., & Miles, J. N. (2004). Interpersonal and role-related schema influence the relationship with the dominant 'voice' in schizophrenia: A comparison of three models. *Psychological Medicine*, 34(8), 1571–1580. <https://doi.org/10.1017/s0033291704002636>
- Bird, V., Leamy, M., Le Boutillier, C., Williams, J., & Slade, M. (2014). *REFOCUS (2nd edition): Promoting recovery in mental health services. Rethink mental illness*.
- Bogen-Johnson, L., de-Visser, R., Strauss, C., & Hayward, M. (2019). "It's just a bit like a rollercoaster": A longitudinal qualitative study exploring a model of the phases of voice hearing. *Psychosis*, 11, 308–318. <https://doi.org/10.1080/17522439.2019.1632375>
- Bogen-Johnston, L., de Visser, R., Strauss, C., & Hayward, M. (2020). A qualitative study exploring how practitioners within early intervention in psychosis services engage with service users' experiences of voice hearing? *Journal of Psychiatric and Mental Health Nursing*, 27(5), 607–615. <https://doi.org/10.1111/jpm.12612>
- Carden, L. J., Saini, P., Seddon, C., Evans, E., & Taylor, P. J. (2020). Shame, social deprivation, and the quality of the voice-hearing relationship. *Psychology and Psychotherapy*, 93(2), 292–308. <https://doi.org/10.1111/papt.12216>
- Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices: A cognitive approach to auditory hallucinations. *British Journal of Psychiatry*, 164(2), 190–201. <https://doi.org/10.1192/bjp.164.2.190>
- Clements, S., Coniglio, F., & Mackenzie, L. (2020). "I'm not telling an illness story. I'm telling a story of opportunity": Making sense of voice hearing experiences. *Community Mental Health Journal*, 56(2), 196–205. <https://doi.org/10.1007/s10597-019-00465-x>
- Coffey, M., & Hewitt, J. (2008). "You don't talk about the voices": Voice hearers and community mental health nurses talk about responding to voice hearing experiences. *Journal of Clinical Nursing*, 17(12), 1591–1600. <https://doi.org/10.1111/j.1365-2702.2007.02185.x>
- Cooke, A. (Ed.) (2017). *Understanding psychosis and schizophrenia* (revised ed.). British Psychological Society. ISBN: 978-1-85433-748-1.

- Corstens, D., & Longden, E. (2013). The origins of voices: Links between life history and voice hearing in a survey of 100 cases. *Psychosis*, 5(3), 270–285. <https://doi.org/10.1080/17522439.2013.816337>
- Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: Implications for research and practice. *Schizophrenia Bulletin*, 40(4), 285–294. <https://doi.org/10.1093/schbul/sbu007>
- Critical Appraisal Skills Programme. (2018). CASP (qualitative) checklist. [online] Available at: <https://casp-uk.net/casp-tools-checklists/>. Accessed: 17 October 2021.
- de Jager, A., Rhodes, P., Beavan, V., Holmes, D., McCabe, K., Thomas, N., McCarthy-Jones, S., Lampshire, D., & Hayward, M. (2016). Investigating the lived experience of recovery in people who hear voices. *Qualitative Health Research*, 26(10), 1409–1423. <https://doi.org/10.1177/1049732315581602>
- de Wet, A., Swartz, L., & Chiliza, B. (2015). Hearing their voices: The lived experience of recovery from first-episode psychosis in schizophrenia in South Africa. *The International Journal of Social Psychiatry*, 61(1), 27–32. <https://doi.org/10.1177/0020764014535753>
- Dilks, S., Tasker, F., & Wren, B. (2010). Managing the impact of psychosis: A grounded theory exploration of recovery processes in psychosis. *British Journal of Clinical Psychology*, 49(1), 87–107. <https://doi.org/10.1348/014466509X439658>
- Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: A powerful alternative for people in distress. *Psychosis*, 5(3), 286–295. <https://doi.org/10.1080/17522439.2013.843020>
- Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., Lehman, A., Tenhula, W. N., Calmes, C., Pasillas, R. M., Peer, J., Kreyenbuhl, J., & Schizophrenia Patient Outcomes Research Team (PORT). (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36(1), 48–70. <https://doi.org/10.1093/schbul/sbp115>
- Dos Santos, B., & Beavan, V. (2015). Qualitatively exploring hearing voices network support groups. *The Journal of Mental Health Training, Education and Practice*, 10, 26–38. <https://doi.org/10.1108/JMHTEP-07-2014-0017>
- Eisenstadt, P., Monteiro, V. B., Diniz, M. J., & Chaves, A. C. (2012). Experience of recovery from a first-episode psychosis. *Early Intervention in Psychiatry*, 6(4), 476–480. <https://doi.org/10.1111/j.1751-7893.2012.00353.x>
- Fallot, R. D., & Harris, M. (2008). Trauma informed approaches to systems of care. *Trauma Psychology Newsletter*, 3(1), 6–7.
- Hall, B., Hayward, M., & Terry, R. (2022). A grounded theory study exploring change processes following cognitive behavioural therapy for distressing voices. *Psychosis*, Advance online publication, 1–13. <https://doi.org/10.1080/17522439.2022.2044896>
- Hayward, M., Awenat, Y., Jones, S. M., Paulik, G., & Berry, K. (2015). Beyond beliefs: A qualitative study of people's opinions about their changing relations with their voices. *Psychosis*, 7, 97–107. <https://doi.org/10.1080/17522439.2014.926388>
- Hazell, C. M., Greenwood, K., Fielding-Smith, S., Rammou, A., Bogen-Johnston, L., Berry, C., Jones, A.-M., & Hayward, M. (2018). Understanding the barriers to accessing symptom-specific cognitive behavior therapy (CBT) for distressing voices: Reflecting on and extending the lessons learnt from the CBT for psychosis literature. *Frontiers in Psychology*, 9, 727. <https://doi.org/10.3389/fpsyg.2018.00727>
- HM Government. (2011). *No health without mental health: A cross government mental health outcomes strategy for people of all ages*. Department of Health.
- Holt, L., & Tickle, A. (2015). "Opening the curtains": How do voice hearers make sense of their voices? *Psychiatric Rehabilitation Journal*, 38(3), 256–262. <https://doi.org/10.1037/prj0000123>
- Johns, L. C., Cannon, M., Singleton, N., Murray, R. M., Farrell, M., Brugha, T., Bebbington, P., Jenkins, R., & Meltzer, H. (2004). Prevalence and correlates of self-reported psychotic symptoms in the British population. *The British Journal of Psychiatry*, 185, 298–305. <https://doi.org/10.1192/bjp.185.4.298>
- Johns, L. C., & van Os, J. (2001). The continuity of psychotic experiences in the general population. *Clinical Psychology Review*, 21(8), 1125–1141. [https://doi.org/10.1016/s0272-7358\(01\)00103-9](https://doi.org/10.1016/s0272-7358(01)00103-9)
- Jose, D., Ramachandra, Lalitha, K., Gandhi, S., Desai, G., & Nagarajaiah (2015). Consumer perspectives on the concept of recovery in schizophrenia: A systematic review. *Asian Journal of Psychiatry*, 14, 13–18. <https://doi.org/10.1016/j.ajp.2015.01.006>
- Kjelby, E., Sinkeviciute, I., Gjestad, R., Kroken, R. A., Løberg, E. M., Jørgensen, H. A., Hugdahl, K., & Johnsen, E. (2015). Suicidality in schizophrenia spectrum disorders: The relationship to hallucinations and persecutory delusions. *European Psychiatry*, 30(7), 830–836. <https://doi.org/10.1016/j.eurpsy.2015.07.003>
- Kråkvik, B., Larøi, F., Kalhovde, A. M., Hugdahl, K., Kompus, K., Salvesen, Ø., Stiles, T. C., & Vedul-Kjelsås, E. (2015). Prevalence of auditory verbal hallucinations in a general population: A group comparison study. *Scandinavian Journal of Psychology*, 56(5), 508–515. <https://doi.org/10.1111/sjop.12236>
- Lam, M. M. L., Pearson, V., Ng, R. M. K., Chiu, C. P. Y., Law, C. W., & Chen, E. Y. H. (2011). What does recovery from psychosis mean? Perceptions of young first-episode patients. *International Journal of Social Psychiatry*, 57(6), 580–587. <https://doi.org/10.1177/0020764010374418>
- Larøi, F., Sommer, I. E., Dirk Blom, J., Fernyhough, C., Ffytche, D. H., Hugdahl, K., Johns, L. C., McCarthy-Jones, S., Preti, A., Raballo, A., Slotema, C. W., Stéphane, M., & Waters, F. (2012). The characteristic features of auditory verbal hallucinations in clinical and nonclinical groups: State-of-the-art overview and future directions. *Schizophrenia Bulletin*, 38(4), 724–733. <https://doi.org/10.1093/schbul/sbs061>
- Law, H., & Morrison, A. P. (2014). Recovery in psychosis: A Delphi study with experts by experience. *Schizophrenia Bulletin*, 40(6), 1347–1355. <https://doi.org/10.1093/schbul/sbu047>
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), 445–452. <https://doi.org/10.1192/bjp.bp.110.083733>
- Loneragan, A. (2017). The meaning of voices in understanding and treating psychosis: Moving towards intervention informed by collaborative formulation. *Europe's Journal of Psychology*, 13(2), 352–365. <https://doi.org/10.5964/ejop.v13i2.1199>
- Longden, E. (2010). Making sense of voices: A personal story of recovery. *Psychosis*, 2(3), 255–259. <https://doi.org/10.1080/17522439.2010.512667>
- Lysaker, P. H., Gagen, E., Moritz, S., & Schweitzer, R. D. (2018). Metacognitive approaches to the treatment of psychosis: A comparison of four approaches. *Psychology Research and Behavior Management*, 11, 341–351. <https://doi.org/10.2147/PRBM.S146446>
- McGlashan, T. H., Levy, S. T., & Carpenter, W. T. Jr. (1975). Integration and sealing over. Clinically distinct recovery styles from schizophrenia. *Archives of General Psychiatry*, 32(10), 1269–1272. <https://doi.org/10.1001/archpsyc.1975.01760280067006>
- Milligan, D., McCarthy-Jones, S., Winthrop, A., & Dudley, R. (2013). Time changes everything? A qualitative investigation of the experience of auditory verbal hallucinations over time. *Psychosis*, 5(2), 107–118. <https://doi.org/10.1080/17522439.2012.667438>
- Morgan, C., Fearon, P., Lappin, J., Heslin, M., Donoghue, K., Lomas, B., Reininghaus, U., Onyejiaka, A., Croudace, T., Jones, P. B., Murray, R. M., Doody, G. A., & Dazzan, P. (2017). Ethnicity and long-term course and outcome of psychotic disorders in a UK sample: The AESOP-10 study. *The British Journal of Psychiatry*, 211(2), 88–94. <https://doi.org/10.1192/bjp.bp.116.193342>

- Morrison, A. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy*, 29(3), 257–276. <https://doi.org/10.1017/S1352465801003010>
- Morrison, A. P., Renton, J. C., French, P., & Bentall, R. P. (2008). *Think you're crazy? Think again*. Routledge.
- Ng, P., Chun, R. W., & Tsun, A. (2012). Recovering from hallucinations: A qualitative study of coping with voices hearing of people with schizophrenia in Hong Kong. *The Scientific World Journal*, 232, 619. <https://doi.org/10.1100/2012/232619>
- NHS England. (2019). *The community mental health framework for adults and older adults*. NHS England.
- Nixon, G., Hagen, B. F., & Peters, T. (2010). Recovery from psychosis: A phenomenological inquiry. *International Journal of Mental Health and Addiction*, 8, 620–635. <https://doi.org/10.1007/s11469-010-9271-8>
- Oakland, L., & Berry, K. (2015). “Lifting the veil”: A qualitative analysis of experiences in hearing voices network groups. *Psychosis*, 7(2), 119–129. <https://doi.org/10.1080/17522439.2014.937451>
- Payne, T., Allen, J., & Lavender, T. (2017). Hearing voices network groups: Experiences of eight voice hearers and the connection to group processes and recovery. *Psychosis*, 9, 205–215. <https://doi.org/10.1080/17522439.2017.1300183>
- Perkins, R., Meddings, S., Williams, S., & Repper, J. (2018). *Recovery colleges: Ten years on*. ImROC.
- Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: A user-led project. *Psychiatric Bulletin*, 31(2), 55–60. <https://doi.org/10.1192/pb.bp.105.008532>
- Rácz, J., Kaló, Z., Kassai, S., Kiss, M., & Pintér, J. N. (2017). The experience of voice hearing and the role of self-help group: An interpretative phenomenological analysis. *International Journal of Social Psychiatry*, 63(4), 307–313. <https://doi.org/10.1177/0020764017700926>
- Romme, M. A., & Escher, A. D. (1989). Hearing voices. *Schizophrenia Bulletin*, 15(2), 209–216. <https://doi.org/10.1093/schbul/15.2.209>
- Romme, M. A., Honig, A., Noorthoorn, E. O., & Escher, A. D. (1992). Coping with hearing voices: An emancipatory approach. *British Journal of Psychiatry*, 161, 99–103. <https://doi.org/10.1192/bjp.161.1.99>
- Romme, M. A., & Morris, M. (2013). The recovery process with hearing voices: Accepting as well as exploring their emotional background through a supported process. *Psychosis*, 5(3), 259–269. <https://doi.org/10.1080/17522439.2013.830641>
- Romme, M. A. J., & Escher, A. D. (2000). *Making sense of voices: A guide for professionals working with voice hearers*. Mind.
- Royal College of Psychiatrists. (2018). *Standards for early intervention in psychosis services* (1st ed.). RC Psych.
- Sanjuan, J., Gonzalez, J. C., Aguilar, E. J., Leal, C., & van Os, J. (2004). Pleasurable auditory hallucinations. *Acta Psychiatrica Scandinavica*, 110(4), 273–278. <https://doi.org/10.1111/j.1600-0447.2004.00336.x>
- Sayer, J., Ritter, S., & Gournay, K. (2000). Beliefs about voices and their effects on coping strategies. *Journal of Advanced Nursing*, 31(5), 1199–1205. <https://doi.org/10.1046/j.1365-2648.2000.01375.x>
- Shea, J. M. (2010). Coming back normal: The process of self-recovery in those with schizophrenia. *Journal of the American Psychiatric Nurses Association*, 16(1), 43–51. <https://doi.org/10.1177/1078390309359197>
- Slade, M. (2009). The contribution of mental health services to recovery. *Journal of Mental Health*, 18(5), 367–371. <https://doi.org/10.3109/09638230903191256>
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1), 12–20. <https://doi.org/10.1002/wps.20084>
- Slade, M., & Longden, E. (2015). Empirical evidence about recovery and mental health. *BMC Psychiatry*, 15, 285. <https://doi.org/10.1186/s12888-015-0678-4>
- Steel, C., Schnackenberg, J., Perry, H., Longden, E., Greenfield, E., & Corstens, D. (2019). Making sense of voices: A case series. *Psychosis*, 11(1), 3–15. <https://doi.org/10.1080/17522439.2018.1559874>
- Stuart, S. R., Tansey, L., & Quayle, E. (2017). What we talk about when we talk about recovery: A systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health*, 26(3), 291–304. <https://doi.org/10.1080/09638237.2016.1222056>
- Styron, T., Utter, L., & Davidson, L. (2017). The hearing voices network: Initial lessons and future directions for mental health professionals and Systems of Care. *The Psychiatric Quarterly*, 88(4), 769–785. <https://doi.org/10.1007/s11126-017-9491-1>
- Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8, 45. <https://doi.org/10.1186/1471-2288-8-45>
- Tse, S., & Ng, R. M. K. (2014). Applying a mental health recovery approach for people from diverse backgrounds: The case of collectivism and individualism paradigms. *Journal of Psychosocial Rehabilitation Mental Health*, 1, 7–13. <https://doi.org/10.1007/s40737-014-0010-5>
- van Os, J., Linscott, R. J., Myin-Germeys, I., Delespaul, P., & Krabbendam, L. (2009). A systematic review and meta-analysis of the psychosis continuum: Evidence for a psychosis proneness-persistence-impairment model of psychotic disorder. *Psychological Medicine*, 39(2), 179–195. <https://doi.org/10.1017/S0033291708003814>
- Vilhauer, R. P. (2015). Depictions of auditory verbal hallucinations in news media. *The International Journal of Social Psychiatry*, 61(1), 58–63. <https://doi.org/10.1177/0020764014535757>
- Waller, S., Reupert, A., Ward, B., McCormick, F., & Kidd, S. (2019). Family-focused recovery: Perspectives from individuals with a mental illness. *International Journal of Mental Health Nursing*, 28(1), 247–255. <https://doi.org/10.1111/inm.12528>
- Weijers, J. G., Ten Kate, C., Debbané, M., Bateman, A. W., de Jong, S., Selten, J.-P. C. J., & Eurelings-Bontekoe, E. H. M. (2020). Mentalization and psychosis: A rationale for the use of mentalization theory to understand and treat non-affective psychotic disorder. *Journal of Contemporary Psychotherapy*, 50(3), 223–232. <https://doi.org/10.1007/s10879-019-09449-0>
- Weijers, J. G., Ten Kate, C., Viechtbauer, W., Rampaart, L., Eurelings, E., & Selten, J. P. (2020). Mentalization-based treatment for psychotic disorder: A rater-blinded, multi-center, randomized controlled trial. *Psychological Medicine*, 51(16), 1–10. Advance online publication. <https://doi.org/10.1017/S0033291720001506>
- WHO. (2014). *Health for the world's adolescents: A second chance in the second decade*. https://apps.who.int/iris/bitstream/handle/10665/112750/WHO_FWC_MCA_14.05_eng.pdf;jsessionid=885A3217AA1EF1CAACF83836DC44443D?sequence=1
- Wood, L., & Alsawy, S. (2018). Recovery in psychosis from a service user perspective: A systematic review and thematic synthesis of current qualitative evidence. *Community Mental Health Journal*, 54(6), 793–804. <https://doi.org/10.1007/s10597-017-0185-9>
- Yanos, P. T., Roe, D., Markus, K., & Lysaker, P. H. (2008). Pathways through internalized stigma and outcomes related to recovery in schizophrenia spectrum disorders. *Psychiatric Services*, 59(12), 1437–1442. <https://doi.org/10.1176/appi.ps.59.12.1437>

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APPENDIX A: REFERENCE LIST OF INCLUDED STUDIES

Bogen-Johnson, L., de-Visser, R., Strauss, C., & Hayward, M. (2019). "It's just a bit like a rollercoaster": a longitudinal qualitative study exploring a model of the phases of voice hearing. *Psychosis*, 11, 308–318. <https://doi.org/10.1080/17522439.2019.1632375>

Clements, S., Coniglio, F., & Mackenzie, L. (2020). "I'm Not Telling an Illness Story. I'm Telling a Story of Opportunity": Making Sense of Voice Hearing Experiences. *Community Mental Health Journal*, 56(2), 196–205. <https://doi.org/10.1007/s10597-019-00465-x>

de Jager, A., Rhodes, P., Beavan, V., Holmes, D., McCabe, K., Thomas, N., ... & Hayward, M. (2016). Investigating the Lived Experience of Recovery in People Who Hear Voices. *Qualitative Health Research*, 26(10), 1409–1423. <https://doi.org/10.1177/1049732315581602>

Dos Santos, B., & Beavan, V. (2015). Qualitatively exploring hearing voices network support groups. *The Journal of Mental Health Training, Education and Practice*, 10, 26–38. <https://doi.org/10.1108/JMHTEP-07-2014-0017>

Hayward, M., Awenat, Y., Jones, S.M., Paulik, G., & Berry, K. (2015). Beyond beliefs: A qualitative study of people's opinions about their changing relations with their voices. *Psychosis*, 7, 97–107. <https://doi.org/10.1080/17522439.2014.926388>

Holt, L., & Tickle, A. (2015). "Opening the curtains": How do voice hearers make sense of their voices? *Psychiatric Rehabilitation Journal*, 38(3), 256–262. DOI:10.1037/prj0000123

Milligan, D., McCarthy-Jones, S., Winthrop, A., & Dudley, R. (2013). Time changes everything? A qualitative investigation of the experience of auditory verbal hallucinations over time. *Psychosis*, 5(2), 107–118. <https://doi.org/10.1080/17522439.2012.667438>

Ng, P., Chun, R. W., & Tsun, A. (2012). Recovering from hallucinations: a qualitative study of coping with voices hearing of people with schizophrenia in Hong Kong. *The Scientific World Journal*, 232619. <https://doi.org/10.1100/2012/232619>

Oakland, L., & Berry, K. (2015). "Lifting the veil": A qualitative analysis of experiences in hearing voices network groups. *Psychosis*, 7(2), 119–129. <https://doi.org/10.1080/17522439.2014.937451>

Payne, T., Allen, J., & Lavender, T. (2017). Hearing Voices Network groups: Experiences of eight voice hearers and the connection to group processes and recovery. *Psychosis*, 9, 205–215. <https://doi.org/10.1080/17522439.2017.1300183>

Rác, J., Kaló, Z., Kassai, S., Kiss, M., & Pintér, J. N. (2017). The experience of voice hearing and the role of self-help group: An interpretative phenomenological analysis. *International Journal of Social Psychiatry*, 63(4), 307–313. <https://doi.org/10.1177/0020764017700926>

Romme, M. A., & Morris, M. (2013). The recovery process with hearing voices: Accepting as well as exploring their emotional background through a supported process. *Psychosis*, 5(3), 259–269. <https://doi.org/10.1080/17522439.2013.830641>

APPENDIX B: FINAL SEARCH STRATEGY

Recover* OR wellbeing OR improve* OR symptom reduc* OR outcome OR change OR rehabilitation

AND

Voice hearing OR voice hear* OR AVH OR hallucinat* OR unusual experience* OR distressing voice* OR hearing voices OR hear voices

AND

Qualitative OR interview OR focus group OR subjective experience OR experience OR phenomenol* OR meaning OR grounded theory OR thematic OR themes OR narrative OR stories