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Clinicians' Perspectives on Distinguishing Between Religious/ Spiritual and Psychotic Phenomena

Jessica K. Parker
Walden University

Walden University

College of Social and Behavioral Sciences

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Jessica Kathleen Parker

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Walden University
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Abstract

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MPhil, Walden University, 2019

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Dissertation Submitted in Partial Fulfillment

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Abstract

Psychosis is a central concept in mental health, yet the concept is unclear. Clinicians are challenged with the task to be able to distinguish psychotic phenomena; however, little is known about how clinicians are able to distinguish religious/spiritual phenomena from psychotic phenomena, as both may be similar in presentation. The focus of this dissertation was on understanding the perspectives and distinguishing processes of mental health professionals when distinguishing between religious/spiritual and psychotic phenomena. Taking a generic qualitative framework approach, the study included face-to-face and telephone interviews with 10 licensed mental health professionals recruited through social media and snowball sampling. Interviews were audiorecorded, transcribed verbatim, and then coded and analyzed using reflexive thematic analysis. Three main themes resulted: trauma is an important consideration when exploring religious/spiritual and psychotic phenomena; clinical experience is multifaceted; and similar language is used to describe religious/spiritual and psychotic phenomena. The study is significant because it gave mental health professionals an opportunity to share their understanding of the phenomena of psychosis as well as their distinguishing processes, and how they talk about religious/spiritual and psychotic phenomena. Future research should focus on (a) the role of trauma when considering psychotic-like phenomena, (b) increasing culture competence related to religious/spiritual competence, and (c) encouraging and facilitating conversations that include cultural religious/spiritual content.

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Dedication

I dedicate this dissertation to Father God, His Son Jesus Christ, and Holy Spirit. I accomplished what You asked me to do. May this dissertation bring You honor and glory.

Next, I would like to dedicate this dissertation to my best friend and loving husband, Richard Kip Parker. Thank you for your many sacrifices for us.

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I would like to acknowledge and humbly thank my Chair, Dr. Susana Verdenelli for her help in this academic, mental, emotional, and spiritual journey. Thank you for pulling me up when I was down and standing firm when I was spiraling in confusion. I appreciate your grace and encouragement.

I would also like to extend thanks to my Second Chair Member, Dr. Sylvia Bigatti, for sharpening my writing edge and guiding me through developing ideas and shaping content. I appreciate your challenges to become a better writer. Thank you for leading me through hard paths.

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Chapter 1: Introduction to the Study

Forms of psychosis are one of the most treated mental health phenomena (Medicine Net, 2018; National Alliance on Mental Illness, 2018). Psychosis and psychotic features are found within schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, bipolar disorders, and other mood disorders. These types of disorders affect up to 2 to 3 million Americans yearly (Medicine Net 2018; Treatment Advocacy Center, 2015). Schizophrenia, the most common psychotic disorder, is globally experienced by more than 21 to 25 million individuals (WHO, 2016). The annual estimated cost for those experiencing psychosis, indirectly and directly, runs into the billions of dollars. In 2013, the Treatment Advocacy Center (2018) reported costs of $155 billion related to criminal justice costs, emergency room care, homeless shelters, unemployment, lost economic productivity, as well as caregivers or family members taking the time to care for the individual with psychosis. Not only is the financial cost high, the emotional and physical costs are as well. Suicide, attempted suicide, and self-harming behaviors are widespread among those experiencing psychosis (Challis, Nielssen, Harris, & Large, 2013; Treatment Advocacy Center, 2018). The risk of high blood sugar and heart disease are also increased with psychosis (NIMH, 2014).

Because psychosis is a large social problem and affects millions of people, it is important that clinicians have a substantial amount of knowledge about it because knowledge about religious and spiritual phenomena may present as psychosis. Undoubtedly, religious and spiritual features are found within psychosis and psychotic-

related disorders; however, the relationship between religion, spirituality, and psychosis is mostly unknown (Koenig, 2009). Hallucinations and delusions are sometimes not easily or quickly distinguished from cultural features, such as religion and spirituality (Phillips, Lukoff & Stone, 2009). The features of religion, spirituality, and psychosis at times will occur simultaneously, manifest distinctly, or are not present. For example, individuals may have religious and spiritual experiences that do not reflect psychotic features in addition to experiencing psychotic features in need of clinical treatment. Other times, individuals may have psychotic features that include religion and spiritual experiences and are in need of clinical treatment.

Psychotic features are an important element in psychological research, assessment and diagnosis, treatment planning, and if appropriate, medication for the management of symptoms. It is important that clinicians develop clinical knowledge and skill in order to appropriately distinguish between psychosis and experiences related to religion and spirituality. To diagnose an individual with a mental health disorder of behavioral health disorder, clinicians must show that clients meet clinical criteria in the *DSM (Diagnostic and Statistical Manual 5 (DSM-5)* (American Psychiatric Association, 2013). This is accomplished by going through a checklist of which certain cognitive, affective, and behavioral symptoms must be present in order to meet clinical criteria and result in a diagnosis. There is a caveat in this diagnosis: the client's worldview and cultural framework, which includes religious and spiritual features, need to be taken into consideration. However, the implementation of this caveat by clinicians is a process that is not readily known. Aside from the clinical training to follow the diagnostic criterion

found in the *DSM-5* (American Psychiatric Association, 2013), there is no clear diagnostic tool to discern between religion, spirituality, and psychosis (Goretzki, Thalbourne & Storm, 2013; Hustof, Hestad, Lien, Moller, & Danbolt, 2013; Wang & Chan, 2014). The goal of this study was to explore the process that clinicians go through to arrive at a clinically appropriate diagnosis, having adequately explored the features of psychosis, religion, and spirituality.

In Chapter 1, I present a brief background of the current literature on the role of religion and spirituality in relation to psychosis and psychotic-related features. I describe this further described in Chapter 2. In Chapter 1, I describe the problem and purpose of the study. I present the research questions, a conceptual framework, and the nature of the study. I then provide the definitions, assumptions, scope and delimitations and limitations. I close the chapter with the potential significance of the study.

Background

In this study I explore how clinicians distinguish between the features of religion, spirituality, and psychosis. I explore the assessment and diagnostic process that clinicians use when examining the similarities and differences between pathological and nonpathological features. To understand this phenomenon, I present a brief background of literature on the topic; it is expounded on in the literature review in Chapter 2. I discuss the overlapping features between religion, spirituality, and psychosis, and how clinicians typically understand those features. I discuss the concept of meaning and how it relates to individuals' worldviews. Finally, I address how clinicians are having

conversations with their clients in order to distinguish between the features of religion, spirituality, and psychosis.

Clinicians acknowledge that clients' religious and spiritual experiences and beliefs may overlap and that they can be symptoms of a psychotic disorder as well as features of positive and negative coping (Mohr, et al., 2010; Moreira-Alemeida, Koenig, & Lucchetti, 2014; Smolak, et al. 2013). Koenig (2009) compared religion and spirituality as a coping tool to psychosis and found that religious and spiritual beliefs and practices are, at times, entangled with psychosis. However, Koenig noted that to differentiate between the symptoms is difficult. The clinician, then, must be able to explore whether religious influences are unhealthy or healthy, and whether they may lead to pathology (Koenig, 2009). Religious and nonreligious beliefs may increase or improve mental health symptoms, and it is important to explore the belief systems in which people perceive and make sense of their experiences (Galek, Ellison, Flannelly, & Silton, 2015). While it is widely assumed that these cultural aspects of the client are taken into consideration when making a diagnosis, some researchers suggest that this is not being done (Glover & Friedman, 2014; Koenig, 2009; Whitley, 2014).

In their review, Menezes and Moreira-Almeida (2010) discussed criteria that could be used to make a differential diagnosis between healthy spiritual experiences and mental disorders of religious content that include an absence of suffering, an absence of negative social and occupational impediments, lack of insight, alignment to a religious/spiritual culture, an absence to other mental health disorders, and increased positive meaning. They concluded, however, that the lack of quality investigations point

to the need for further exploration of the relationship that psychosis has with religion and spirituality. The authors agree that simple or generalized approaches are not appropriate when addressing psychosis and religion and spirituality.

The features of religion, spirituality, and psychosis overlap and are difficult to distinguish. Some clinicians report avoiding discussing religious and spiritual matters because they lack the proper training to ethically and effectively address them (Vieten, et al., 2016; Whitley, 2014). Currently, clinicians do not receive much, if any, training to address religious or spiritual facets in the counseling setting (Vieten et al. 2016). Clinicians ought to be aware of, and seek to understand, the client's religious and spiritual framework through clinical discussions (Koenig, 2009) and respectful discourse, rather than treat the client with dismissive or authoritarian condescension (Whitley, 2014). Due to the lack of research on how clinicians assess religious and spiritual experiences compared to psychosis, I studied the process clinician's use when exploring overlapping typical and atypical features.

Problem Statement

Religious and spiritual experiences, beliefs, and behaviors manifest differently by culture and religion. In their practices, clinicians may find religious and spiritual content that appears to consist of pathological delusions and hallucinations. For example, a client may report they have transcendent powers, believe they are chosen by a transcendent being for a certain task, are experiencing mystical phenomena, or are experiencing visions. These scenarios fit *DSM-5* (American Psychiatric Association, 2013) criteria for psychosis, while at the same time fitting within religious and spiritual beliefs, groups, and

frameworks that are not considered pathological, potentially creating a challenge for the clinician.

Researchers found that distinguishing clients' religious and spiritual beliefs and experiences that are normative within their cultural context from pathological symptoms needing clinical treatment may be especially challenging (Kleiger & Khadivi, 2015). This inability to distinguish properly may result in a misdiagnosis or a poor outcome to treatment. In addition, when clients are of a different culture than the clinician, the process of diagnostic assessment regarding psychosis can become even more complicated. Kleiger and Khadivi (2015) advise a thorough exploration of the client's cultural influences to avoid giving a "culturocentric collection of false-positive diagnoses" (p. 3).

There is a significant body of literature that describes the role of religion and spirituality in the lives of those experiencing psychosis and psychotic-related disorders (Hustoft, Hestad, Lien, Moller, & Danbolt, 2013; Moreira-Almeida, Koenig & Lucchetti, 2014; Smolak, et al. 2013). However, what is missing from the extant research is an understanding of the how the prior step of distinguishing features is accomplished and how the features play a role in the client's experience. The omission of cultural religious and spiritual affiliations in the diagnosis of pathology can be consequential, as clinicians are tasked with distinguish among the phenomena of religion, spirituality, and psychosis in order to appropriately diagnose their clients. Effective diagnosis and treatment is based upon the ability of the clinician to distinguish between religion, spirituality, and

psychosis. This ability develops from an appropriate understanding of the features of each, which is the focus of the study.

When assessing for mental health disorders, the clinician's goal is not to over-pathologize the symptoms or prematurely attribute the symptom to the clients' culture, but to rightly distinguish the presenting symptoms as either pathological, reflective of a psychotic phenomenon (Kleiger & Khadivi, 2015), or as part of a religious or spiritual framework, in order to arrive to a clinically appropriate diagnosis (Gale, 2014; Rapsomiti, 2014). This dissertation will fill a gap in understanding how clinicians understand, and therefore distinguish between, (a) cultural beliefs and experiences and (b) religious and spiritual psychotic symptomology.

Purpose of the Study

The purpose of the study was to understand how clinicians distinguish religious and spiritual experiences and beliefs from psychotic experiences and beliefs. During the development of the project, the intention was to differentiate religious from spiritual phenomena; however, participants used both terms interchangeably and tended to use the term *spiritual* more than *religious*. The participants did not make or notice any particular difference between the two. Therefore, in this study I used the term religious/spiritual to indicate spiritual phenomena and that concept involves religious phenomena. To address the clinical distinguishing process, a generic qualitative approach was used.

Research Questions

This study was guided by two qualitative questions:

RQ1. How do clinicians describe their understanding of clients' religious/spiritual experiences and beliefs as distinct symptoms from psychotic symptoms needing clinical care/treatment?

RQ2. How do clinicians engage in conversation and explore their clients' religious/spiritual experiences and beliefs and psychotic symptoms needing clinical care/treatment?

Conceptual Framework

To research the process of how clinicians take into consideration the themes undergirding the symptoms of psychosis in the forms of delusions and hallucinations, a multicultural framework was used. An important feature of the multicultural framework is that it includes humanistic underpinnings of nonjudgmental listening and acceptance. Multiculturalism and humanism contain the feature of *worldview*. Understanding the different worldviews that people have is important because they influence people's behaviors, beliefs, and the decisions they make, in spite of their efforts to be objective (Glover & Friedman, 2015). A multicultural framework takes into consideration the implicit importance of religion/spirituality as a means to understand the client and the symptoms the client is experiencing.

One may attempt to operate as a "culturally neutral" or "objective" individual; however, "such etic perspectives always come from someone's own cultural perspective" (Glover & Friedman, 2015, p. 30). This may or may not acknowledge the client's perspective of their religious/spiritual experience and beliefs. These perspectives are important when distinguishing the differences between religion/spirituality and

psychosis. A multicultural framework shifts assists the clinician as an outside observer to empathize with, and attempt to understand, the client's unique and subjective perspective.

In this, clinicians may be afforded opportunities to work with the concept of *meaning* to explore the unique perspective of the client. According to Frankl, meaning may change but the need for meaning is constant (1946/1992). Frankl also posited that meaning is not to endure meaninglessness or to suffer just for sufferings sake, but to "bear his incapacity to grasp its unconditional meaningfulness in rational terms" (p. 122). In creating meaning, a person experiences phenomena and interprets the phenomena, relative to their knowledge and the value of the experience. People typically strive for psychological homeostasis and will attempt to categorize life events to maintain a state of stability congruent to themselves. Meaning is an important aspect for those who have experienced psychosis (Murphy, 2000) as well as for those who experience profound religious/spiritual phenomena.

A multicultural framework was used to gain insight on the process that clinicians go through when attempting to understand the client's meaning related to religious/spiritual and psychotic symptoms. A multicultural framework was used to explore the meaning the clinician and the client places upon religious/spiritual and psychotic symptoms that may be reported as valued, unimportant, or nonexistent. In this study, by using a multicultural framework, the religious/spiritual or psychotic meaning of a belief, experience, or behavior may align either as a cultural feature or a feature of psychopathology.

Nature of the Study

In this study, I used a generic qualitative research approach with a flexible design. A substantial strength of the generic approach is its ability to explore new research questions, create new methodologies, and advance theory (Kahlke, 2014). A generic qualitative approach does not hold to traditional established analytical boundaries and cautions against method slurring (Kahlke, 2014). The descriptive qualitative approach and interpretive description approach provided unrestricted flexibility for the data to speak in the context of the study and provided increased ability for analysis (Caelli, Ray, & Mill, 2003). Thus, identifying religious/spiritual and psychotic phenomena seem to be better done through generic qualitative methods rather than quantitative statistics as descriptive language could provide insight to the distinguishing process.

The generic qualitative approach was adaptable and aligned with the goals of this study. The study presented data that will be used to help understand the overlapping grey area between religious/spiritual and psychotic phenomena. Understanding how clinicians distinguish among (a) what is healthy and within normal limits and (b) what is pathological (in terms of religious/spiritual experiences and beliefs) and (c) psychotic experiences and beliefs is invaluable. In this research design, specific and general terms used to describe the differences and similarities of phenomena were analyzed for congruence and contrasting identifiers. For this reason it is important to clarify key concepts.

The specific features of psychosis, religion, spirituality and their accompanying beliefs and behaviors play a part in the diagnostic process of the clinician. The diagnostic

process is a conceptualization of the client's presenting symptoms through evaluation of the facts, exploring relevant evidence from the client and others involved, including family, friends, and professionals, and examining the effects of those symptoms. The outcome of this process will determine the diagnostic constellation of a specific mental health or behavioral health disorder. The features are evaluated in light of academic and professional training, and personal experiences in the clinical diagnostic interview. The following definitions are provided in order to clarify the features studied to provide context to the qualitative research questions presented.

Definitions

Culture: collective customs and values of a social group. Culture includes "behaviors, attitudes, feelings, and cognitions" that are "mediated by biological, psychological, historical, and political events" (Hays & Erford, 2010, p. 5)

Cultural encapsulation: is defined by Heppner, Wang, Heppner and Wing (2007) to describe "counselors apply[ing] their own experience to clients' experience without acknowledging the potentially different cultures, values, and worldviews" (p. 433).

Delusion: "Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence" (American Psychiatric Association, 2013, p. 87). Delusions may be bizarre or nonbizarre. The types of delusions are Delusions of persecution or Paranoid Delusions; Delusions of reference; Delusions of grandeur; and Delusions of control. Religious Delusions are classified within Delusions of grandeur and are otherwise called Grandiose Delusions.

Emic: a perspective from within the culture being studied (Knabb & Wang, 2019).

Etic: a perspective outside of the culture being studied (Knabb & Wang, 2019).

Hallucination: "Hallucinations are perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control" (American Psychiatric Association, 2013, p. 87)." The most common types of hallucinations are auditory or hearing voices.

Meaning: is defined by belief in meaning and purpose in life, experiencing positive and negative affect, and may include religious beliefs and behaviors (Galek, Ellison, Flannelly & Silton, 2015). Meaning is synonymous with worldview. In the study, the word meaning will be used to encompass the concept of worldview.

Multicultural: integration of cultural identity relating to subgroups of various groups which include, but are not limited to, race, age, gender, socioeconomic status, disability, religion, and spirituality (Hays & Erford, 2010).

Mystical: in the most rudimentary sense is an experience with profound intangible sensations. Mysticism is not easily defined, lacks uniformity across research, and presents as a spectrum with wide variation distribution (Lukoff & Lu, 1988).

Nonordinary state: an inner spontaneous experience of phenomena that may interfere with behavioral functioning (Grof & Grof, 1989).

Psychosis: as a disturbance in thought and emotion impacting and impairing reality organized on a gradient or spectrum (American Psychiatric Association, 2013). Simultaneously, the core concept of psychosis is ambiguous (Adan-Manes & Ramos-Gorostiza, 2016).

Religion: an organized group possessing focused behaviors and rituals related to the groups chosen transcendent and supernatural truth or reality (Huguelet & Koenig, 2009).

Spirituality: possessing diffuse existential and transcendent boundaries and provides the client subjective freedom of expression relating to their spiritual framework encompassing their experiences, beliefs, and behaviors (Huguelet & Koenig, 2009).

Spiritual emergency: Spiritual emergencies may be triggered after an intense emotional experience, positive and negative; may be physically based, e.g. lack of sleep, accident, sickness; and may emerge while engaged in spiritual activities. Grof and Grof (1989) define a spiritual emergency when a crisis and opportunity present to increase levels of awareness. Spiritual emergencies may have an unexpected onset, last a few weeks, and disrupt normal activities (Grof, 2006). Spiritual emergencies are unique to the individual. Spiritual emergencies are also called a spiritual crisis (Grof & Grof, 1989) and transpersonal crises (Grof, 2017)

Transpersonal: relating to transcendence through "spiritual, mystical, religious, occult, magical, and paranormal" phenomena (Grof & Grof, 1989, p. 10).

Worldview: a global meaning making system (Starnino, 2016). The origin and definition of worldview comes from the German word, *Weltanschauung*. This word means that it encompasses the way that one views their world, other people, and themselves. Worldview is similar to meaning. As previously mentioned, meaning will be used throughout this study to encompass the concept of worldview unless noted.

Assumptions

This study was based on a series of assumptions: I assumed that (a) participants had an interest in this topic and responded honestly and professionally; (b) participants gave clear and accurate responses to the best of their ability; (c) participants understood the research questions and had good linguistic ability to verbalize the distinguishing process in simple and understandable terms; (d) the semistructured interview allowed great flexibility in guiding the course of the interview to obtain the richest data; (e) the analyzed qualitative data showed themes related to types of theoretical psychology frameworks, diverse types of worldviews, and the content and degree of clinical conversations emerged.

Scope and Delimitations

The scope of this study was to understand the distinguishing process that mental health clinicians use when distinguishing between features, such as religion/spirituality, that may overlap with psychosis. I was not seeking to explore extreme beliefs and behaviors related to religion/spirituality and psychotic features. Other mental health disorders were not examined. For example, substance use disorders and substance induced psychotic disorders were not examined because the substance would be considered the prime factor in the experience.

Clinicians approved for this study were mental health professionals in the United States and included psychiatrists, psychologists, mental health counselors, and social workers.

Limitations

This study was subject to three limitations. First, a limitation may be due to the small and unique sample available. The results from the study may not be transferrable beyond the specific population from which the sample was drawn. Second, given the sensitive topic, I may not have received fully honest responses. Third, some clinicians' results may not have accurately reflected shared informed clinical judgment of all members of the included population.

Significance

The results of this qualitative study may help clinicians grow in cultural competence by giving them information to improve their ability to distinguish religious/spiritual experiences and beliefs from psychotic experiences and beliefs. Rapsomatioti (2014) affirms that the clinician's task in distinguishing religious/spiritual features from psychotic features is "extremely complex" (p. 196) and Koenig (2009) acknowledges that religious/spiritual beliefs and experiences are "intricately entangled" with pathological features. Psychologists and other mental health professionals need to become more culturally competent (Glover & Friedman, 2015; Whitley 2005). One aspect of cultural competency is increasing clinicians' ability to address religious/spiritual facets in clinical practice. The results of this study may help clinicians understand this distinguishing process in greater detail.

Summary

Studies on distinguishing religious/spiritual features from psychotic features are difficult to find, qualitative methods are scarce, and clinicians have not been studied in

depth. While many quantitative methods use surveys on how clients report their experiences, there is a lack of qualitative research on the process clinicians use to distinguish religious/spiritual from psychotic phenomena.

This qualitative study explored the clinical process of distinguishing between pathological religious/spiritual delusions and hallucinations that need clinical treatment and religious/spiritual cultural expressions that do not need clinical treatment. Religious/spiritual features are commonly found within psychosis and psychotic-related disorders; however, religious/spiritual features are not always indicators of psychosis or psychotic-related disorders. The findings from the study may help clinicians understand the distinguishing process when individuals present with religious/spiritual or psychotic features as well as add knowledge to the field. The study may lead to positive social change, as it may provide information to classify and address those features in clinically appropriate ways.

In chapter 2, I review literature on the entangled relationship between the religious/spiritual and psychosis; how meaning and worldview factor into how phenomena are presented; and the type of clinical conversations that are being held in order to distinguish normal features that do not need clinical attention from pathological features that need clinical treatment. In Chapter 2, I provide a review of the related literature. Chapter 3 contains the study's design and methodology. Chapter 4 includes the results of the data, and in Chapter 5, I discuss the interpretation of the results, the implications, and conclusions of the study.

Chapter 2: Literature Review

Introduction

The profound question, "Could a delusion be a description of an authentic spiritual experience?" asked by Rapsomatioti (2014, p. 204) is important to entertain. To address this question, mental health clinicians are presented with a challenging task: to distinguish between religious/spiritual and psychotic features.

As the field of psychology continues to grow and communities become more multicultural, a basic understanding is needed about various populations' religious/spiritual features in order to deliver effective, evidenced-based therapy. The features of religion/spirituality and psychosis may overlap, may manifest as distinct yet simultaneous, and, at times, be difficult to differentiate.

In this chapter, I describe the literature that supports the study. I discuss the literature research strategy, the key concepts I focused on that supported the study, as well as describe the conceptual framework. First, I review the definitions and the common understanding of religion/spirituality and psychosis among mental health providers. Then I examine how religion/spirituality may be present in clinical encounters. Finally, I review how cultural features are viewed and given meaning by the client and the clinician. I end the chapter with two relevant case studies. The information I provide support addressing cultural features in a clinical setting because it can be complex and obtaining an accurate diagnosis can be challenging.

Literature Research Strategy

The databases that I used for this review were PsycINFO, Google Scholar, and Medscape. PsycINFO was used to find peer-reviewed articles to identify a gap in the literature relating to the clinical distinguishing process between religious/spiritual and psychotic features. Google Scholar was used to find current peer-reviewed scientific sources. Medscape was used to locate current psychiatric information. The following keywords were used: *awakening, consciousness, delusion, dissociation, hallucination, mystical, psychosis, religion, schizophrenia, spiritual, states, transcendent, transpersonal.* While most of the articles were published within the last 5 years, older, seminal articles on the unclear relationship between religion/spirituality and psychosis were included as well.

Conceptual Framework

I took a multicultural–humanistic approach in this dissertation, guided by multiculturalism and transpersonalism. A multicultural approach allowed me to encompass a broad base of features that allowed for significant depth. A multicultural approach contains elements of humanism and postulates that the clinician is not the expert; rather, the client is the expert about his or her experiences. Humanism promotes the idea that the clinician is to present a climate of growth through a respect for the subjective religious and spiritual experience of clients and trust that clients can make the best choice for themselves (Corey, 2009). Transpersonal psychology focuses on higher levels of self-awareness, higher levels of awareness of others, and participates in meaningful religious/spiritual experiences.

Through the conceptual frameworks of multiculturalism, humanism, and transpersonalism, the clinician assists the client through evidenced-based treatment realigning the pathological cognitive, affective, and behavioral features to increase psychological wellbeing and functioning. In this practice it is important to note that the client's cognitive and affective lens in which to process the world may differ from the clinicians. In the process of human perception an individual has to see something, perceive something through etic and emic knowledge, and understand the experience according to the meaning that is assigned by the individual. These are important factors when discussing meaning and worldview. It is important to note, that within any worldview certain components are included in the foundation of learning and understanding to create meaning. How an individual's framework of meaning is developed may affect the way the individual processes information.

Multiculturalism

Multiculturalism is a philosophy that acknowledges diverse cultures exist in close proximity of one another. The rationale for the selection of a multicultural lens is that was the most appropriate lens to explore multifaceted cultural features that may appear as pathological, but after further exploration are found to be a part of a cultural framework. A multicultural framework was useful as it considers that different cultures have different beliefs and values that may not fit within a dominant Western framework. On one hand, Knabb (2014) encouraged clinicians to "work within the patient's own language" (p. 708), which would include cultural features, as an effective intervention when addressing delusions with religious underpinnings. On the other hand, Valanciute and Thampy

(2011) proposed "placing [psychiatric care] within a Western cultural context" (p. 841). This stance may be problematic when addressing multicultural religious/spiritual phenomena, as it does not align within a multicultural framework.

Meaning is important within the multicultural framework. Each culture has its diverse origin, beliefs, behaviors, systems and roles, and overall worldview. Multiculturalism calls for the respect for the wide range of diversity. As shown over the last three versions of the *DSM,* it is clear that the American Psychiatric Association is moving toward a more inclusive yet concise description of mental health symptoms, especially when considering religious/spiritual features. Culture is gaining more attention and is welcomed as personal identifier. As our society becomes more multicultural it benefits clinicians to be culturally competent and informed regarding the role and value of religious/spiritual beliefs and behaviors. Whitley (2014) asserted that cultural competence includes having the realization that the inclusion or omission of religion and spirituality influences cognitive and behavioral frameworks. A multicultural framework takes into consideration the implicit importance of religion/spirituality as a means to understand the client and the symptoms the client is experiencing.

Transpersonal Psychology

As previously noted, transpersonal psychology transpersonal psychology includes human transcendence through "spiritual, mystical, religious, occult, magical, and paranormal" phenomena (Grof & Grof, 1989, p. 10). These experiences may occur through nonordinary states. Transpersonal psychology has a high degree of fluid construction yet lacks concrete definitions. As religious/spiritual themes are commonly

found within transpersonal psychology, it provided a framework of understanding religious/spiritual phenomena that may present as pathological or psychotic, but are not. This idea was introduced in Grof and Grof's (1989) book, *Spiritual Emergency.* This ideological introduction changed the landscape of psychology.

Transpersonal psychology does not fit neatly within Western psychology. A major theme in transpersonal psychology is that nonordinary states may present as spontaneous, may disrupt the individual's functioning of living, and at first may appear pathological; yet, they may be considered a spiritual emergence or spiritual emergency (Grof & Grof, 1989; Grof, 2006). This is interesting to ponder, as psychosis and nonordinary states do not present as intentional acts. Suggesting that there is more to learn from nonordinary states, Grof states

> Western Industrial civilization is the only group in the entire human history that doesn't hold nonordinary states in great esteem, and doesn't have any use for them, actually has pathologized them; every other culture has spent a lot of time and energy trying to develop ways of inducing nonordinary states and they cover a wide range (Transpersonal Project. (2014).

Religion, Spirituality, and Psychosis

Psychotic Spectrum in the *DSM*

The newest edition of the *DSM-5* (American Psychiatric Association, 2013) presents psychosis and psychotic-related disorders within a dimensional spectrum to describe the type and severity of mental health symptoms. Diagnostically, there are other mental health diagnoses that overlap and have grey portions, such as autism and bipolar

disorder; however, most are held in discrete categories. The loss of sleep, the increase in worry, lack of energy, and inability to manage emotional states are typically determined through quantifiable data to qualify for a mental health disorder. Psychosis and psychotic-related disorders are not as discrete and are observed and described upon a gradient or spectrum.

The spectrum was presented to clarify how to address psychotic phenomena including the levels of cognition, the emotional response or lack of response, presentation of positive symptoms, and mood changes. Other authors propose that psychosis is not clearly defined and that the term may be used across clinical, legal, and social aspects (Adan-Manes & Ramos-Gorostiza, 2016). In understanding the psychotic spectrum it is important to note that psychotic-related disorders are heterogeneous and present in diverse ways (American Psychiatric Association, 2013). A significant distinction in the *DSM-5* (2013) is that it "no longer has the requirement that the delusions must be nonbizarre; a specifier is now included for bizarre type delusions" (p. 810) to maintain *DSM IV-TR* (American Psychiatric Association, 2000) alignment. Interestingly, religious delusions are held stronger than other types of delusions, and range from nonpathological to implausible assertion (Koenig, 2009).

A phenomenon in the exploration of religious/spiritual features is that while it is part of a clinical set of disorders, it may also manifest independently of any mental health disorder. The phenomenon of psychosis may be difficult for clinicians to distinguish as a mental health disorder as the clinical presentation may not present with clear and distinct features of psychosis. Psychosis may manifest with religious/spiritual content that are a

part of the disorder, which at other times are distinct from psychosis. Therefore, it is important to be aware of the features contained within the *DSM-5* presentation of what is termed culture bound.

Cultural Features in the *DSM*

The *DSM* is the primary way of communicating current diagnostic criteria relating to the evolving understanding of mental health and behavioral health and how religion/spirituality are intertwined. At times, boundary lines between religion and spirituality and psychosis may blur (Ng, 2007; Valanciute & Thampy, 2011; Bhargav, Jagnnathan, Raghuram, Srinivasan & Gangadhar, 2015) and are difficult to disentangle. For this study, it was important to look at the evolution of the *DSM* from 1987 to present date in order to gain a general understanding of how clinicians have viewed the role of religion/spirituality relating to mental health disorders and psychotic-related features.

The *DSM III-R* (American Psychiatric Association, 1987) provided basic criteria when distinguishing between the various types of psychosis and psychotic-related disorders and added multiple specifiers to the disorders. Simple caveats were given when distinguishing phenomena to consider the individuals culture. Thirteen years later, the *DSM-IV TR* (American Psychiatric Association, 2000) included a specific section to address cultural beliefs and behaviors. The Cultural Formulation and Glossary of Culture-bound Symptoms (pp. 897-903) provided a specific formulation to assist clinicians in distinguishing cultural phenomena and mental health disorders by way of "systematically evaluating and reporting the impact of the individual's cultural context" (p. 897). The formulation directs the clinician to explore the

> cultural identity of the individual; cultural explanations of the individual's illness; cultural factors related to psychosocial environment and levels of functioning; cultural elements of the relationship between the individual and the clinician; [and] overall cultural assessment for diagnosis and care. (pp. 897-898)

Notably, the *DSM-5* does not have a similar introduction to its Culture Concepts section. The second part of the *DSM-IV-TR* Appendix provides an overview of specific "culture bound syndromes and idioms of distress" (p. 899). The concept of culture bound will be addressed in more detail in a subsequent section.

The *DSM-5* (American Psychiatric Association, 2013) continues with the caveat that some psychotic features, hallucinations, are culturally appropriate, while also proving an additional support in distinguishing mental health phenomena relating to religious and spiritual features in the Glossary of Cultural Concepts of Distress. In this section the numbers of syndromes were reduced from 25 to nine and certain cultural syndromes were combined in the presentation as similar. Cultural features are presented in a more organized fashion, a description of the cultural phenomena is provided, and is followed by Related Conditions in other Cultural Contexts describing how similar regions and ethnic groups believe and behave, and Related Conditions in the *DSM-5* that correlate to the cultural descriptions (p. 833-837). From this we can deduce that in the short time from the *DSM III* (American Psychiatric Association, 1987) to the *DSM-5* (American Psychiatric Association, 2013) the increase of demand for multicultural competence continues to rise.

The American Psychiatric Association (2013) appropriately notes that hallucinations may be a normal part of religious experience in certain cultural contexts and we can expect that homogeneity is found within religious groups (Wellman et al, 2014). The expectation to find similar phenomena is correlated by the *DSM-5* Culture section where similar presentations of religious/spiritual phenomena are found in various cultural groups. This feature is welcome as it brings some clarity to unclear cultural features and provides direction to a more fluid presentation of psychic phenomena, as well as the notable advancement in the *DSM-5* with the presentation of the psychotic spectrum. As the *DSM* acts as a living document and is organic, clinicians should expect to see further research and science that supports effective and evidenced based treatment.

Meaning of Culture Bound

The *DSM-5* (American Psychiatric Association, 2013) shows respect for cultural considerations as it increased awareness relating to symptoms and features by moving away from a discrete list of phenomena to that which occurs as similar in other cultures. However, the idea that culture is limited and only valued within the group and is limited to certain demographics seems to be shortsighted. The demographics relating to a specific geographical location and perceived connection to that location are not the sole qualifiers for culture. People often choose to adopt an unknown culture. Multicultural relationships offer inclusivity to worldviews previously unknown. Religious/spiritual features transcend geographic boundaries and are not solidly bound to a certain race, ethnic group, or society. Adjusting the rigidity of categorizing symptoms as culture bound provides the client and the clinician greater therapeutic latitude.

As our cultural knowledge base has progressed, individuals have the choice of which cultural identity they choose to adopt internally and externally. As a part of this process the individual chooses with whom to affiliate, what behaviors to adopt, and the value system of the cultural identity. Communities fluctuate as cultures and societies change as immigration adds more levels of societal fabric (Barbieri, Zani, & Sonn, 2014). Hibbard (2007) affirms that being born into a specific group does not mean an individual will internalize and present with features relating to that cultural identity.

Role of Religion and Spirituality in Mental Health

In most cases, religion and spirituality are not synonymous and bear different categorical characteristics (Hugulet & Koenig, 2009). Religion is defined to indicate "specific behavioral, social, doctrinal, and denominational characteristics," while spirituality encompasses the "ultimate questions about life's meaning as it relates to the transcendent, which may or may not arise from formal religious traditions" (Hugulet & Koenig, 2009, p. 1). Religion and spirituality often accompany mental health treatment and mental health disorders. In the next section, I discuss religion and spirituality as a coping support and describing religious and spiritual phenomena.

Religion and Spirituality as a Coping Support

Religion and spirituality may be used as coping support, and brought into the clinical relationship by the client. Likewise, spirituality is important for those experiencing psychosis as there are positive coping elements found within spiritual frameworks (Hustoft, Hestad, Lien, Møller, and Danbolt, 2013; Sharma, Kumari & Kumar, 2017). Additionally, significant strides have been made in understanding the

roles of the clients' religion and spirituality in their coping and recovery (Starnino, 2016). In addition to the client potentially presenting with religious/spiritual coping beliefs and behaviors, the clinician may offer religious/spiritual coping tools in mental health treatment. Some clinicians are offering nontraditional religious and spiritual tools in their clinical practice (Barton, 2011; Knabb, 2012).

Describing Religion and Spiritual Phenomena

Psychosis may present as heterogeneous and may be difficult to describe. The presentation of psychosis is varied and can include religious/spiritual phenomena. While the psychotic phenomena with religious/spiritual features may be difficult to describe, religious/spiritual features are described in similar ways. The lack of a common language illustrates the need for a common language when speaking with other clinicians when distinguishing between religious/spiritual and psychotic phenomena. While at times challenging, individuals will attempt to verbalize or articulate in some form, intangible and immeasurable experiences. Various religious/spiritual cultural groups may describe the process of appraising an internal experience and discussing the theme, content, and form of a phenomenon similarly.

In a study of Christian mega churches across America (Wellman, Corcoran & Stockly, 2014), individuals used terms like *spiritual gifts, calling, energy, spiritual high*, and *filled* to describe part of the group transcendental experience. The Holy Spirit was specifically described as *tangible*. Individuals reported a receiving a *transfer of energy* from a spiritual leader. One person described an experience as if they had "walked through the waters but never got wet," (p. 662). A study of non-Native Sweat Lodge

practitioners described similar transcendent experiences and reported sensing *energies* and feeling the presence of a *spirit or spirits* (Hibbard, 2007).

Energy, as a religious and spiritual feature, was also found in Henry's (2013) work, suggesting that awareness of the spiritual energy produced through Islamic prayers, use of religious symbols, and healing metaphors may be beneficial for religious Muslim clients in psychotherapeutic work. Similar transcendental themes of *out of body experiences*, *belonging to something greater than the self*, *connectivity*, *past lives*, *death experiences*, and *visions* are found in Grof's (2006) and Hibbard's (2007) transpersonal work. In addition, some forms of centering prayer developed by Catholic Mystics overlap with Buddhist teachings in their descriptions of going beyond rational thoughts and feelings and into the center of the person where God is located (Knabb, 2012). In addition, this author reports that centering prayer may be described as seeking a higher level of spiritual awareness, a mystical practice where an individual may have an experience with the presence of God and transcend tangible realities. Knabb (2012) also draws attention to the similarities between Western Catholic Mysticism and Eastern Buddhism in spiritual practices while acknowledging foundational differences in the concept of god/God.

Notably, the concepts of engagement with transcendent entities and energy are found among diverse cultural groups in their religious and spiritual expression. As the word energy is used across multiple cultural groups it is beneficial to understand the cultural meaning of the word. This is especially important as words do not directly translate across languages and may be misinterpreted. For example, Yoga energy is

different from Christian energy. Yoga uses eight terms to describe Hindu and Buddhist forms of energy. *Hatha* is a form of seeking balance; *vinyasa* is increasing consciousness; *iyengar* is the penetration of the physical body to the inner layers of the mind, energy, and spirit; ritual *ashtanga* is purification of the body and mind; *bikram* as a similar form of *hatha; yin* or *daoist* is mindful meditation and enhancing the body's energy or *qui*; and *kundalini* is used to tap into inner energy and release higher levels of consciousness. In contrast, Christianity uses eight words to describe energy. *dunamis* is similar to explosive dynamite; *ischus* is force, strength, ability; *exousia* is relative to authority; k*ratos* is dominating power and is similar to *ekballo* the commanding ability to deprive something or someone of power and influence; *arche* a ruling power; *eutonos* is convincing and confrontational power; and *energos*, divine energy.

This illustrates that there may be multiple meanings to phenomena within a single cultural group when using the same word, energy, to describe a phenomenal experiences. Conversely, there are multiple meanings used to describe phenomena across varied cultural groups. One can conclude from the resources evaluated that religious/spiritual language is similar across cultural groups and may be difficult to disentangle. In addition, the same language used to describe religious/spiritual features may be interpreted differently by other cultural groups and subcultures.

Meaning and Worldview in the Clinical Encounter

The concept of meaning and worldview are foundational to study in exploring how clinicians distinguish religious/spiritual and psychotic phenomena. As introduced in Chapter 1, worldviews are internal frameworks of meaning including personal

philosophical belief systems in which people make sense of their experiences (Galek, Ellison, Flannelly & Silton, 2015) and therefore create meaning. Meaning affects how perceptions of religious/spiritual features are considered. One can conclude that the way a client may attribute meaning to a religious/spiritual or psychotic feature may be accepted or rejected by the clinician. As previously noted, meaning and worldview are similar and are referred to as meaning unless otherwise noted.

Meaning is constructed through interpretations of verbal and nonverbal communication. Meaning is multilayered and multilayered interpretations may be embedded in the culture (Flanagan, 2018b; Ting, 2012). Decoding different meanings from different languages and cultures is a challenging interpretive task. An example of this is the differences in meaning of hand gestures in different geographic regions. Recognizing and respect are primary features in cultural adaptation and transcultural competence (Glover & Friedman, 2015).

The approach to identify and transcend cultural boundaries in relation to meaning is considered culturally competent and appropriate when assessing and diagnosing psychosis and psychotic-related disorders. One can conclude from the literature that acknowledgement and verbalization of meaning is a recommended culturally competent strategy.

Cultural competency involves sensitivity, knowledge, and skills that may shift from client to client (Flanagan, 2018a). This suggests that operating in cultural encapsulation and solely relying on Western meaning focusing on measureable scientific steps is not recommended. On the other hand, some authors suggest that attributing

Western meaning to cultural phenomena is acceptable practice. Valanciute and Thampy (2011) proposed:

> [The] important issue of the potential variance between the individual's beliefs, spirituality and established diagnosis and opinions within a particular socio-cultural setting…highlights the importance of understanding differing and varying philosophical and spiritual practices, applying it to clinical psychiatric care and placing it within a Western cultural context. (p. 841.)

One can conclude that decisions about a person sometimes depend on the worldview of the person making the decision, not necessarily the person experiencing the phenomena (Koenig, 2009).

Clinicians are encouraged to adjust their lens of meaning to provide room to explore religious and spiritual concepts that are unfamiliar to them (Glover & Friedman, 2015; Happner, Wang, Heppner & Wing, 2012) and may appear as psychotic. This type of cultural flexibility is challenging, yet it is necessary to become transculturally competent through proactive shifting within the demands of evolutionary contexts. The literature suggests that clinicians should support the client's emerging understanding and meaning of the phenomena they are experiencing and not impose their clinical worldview and meaning of a phenomenon. Bourke (2014) asserted that it is "reasonable" to expect that researchers, and in cases like this, mental health professionals, worldviews may affect the clinical process.

Meaning as an Organic Construct

The concept of meaning is a collective agreement by one or more persons. Meaning evolves over time as agreement on a certain thing at a certain time with the knowledge that is available at that time. The logical expectation is that the understanding and ideas about a phenomenon organically evolves and unfolds over time. The interpretation of a phenomenon is the process of making meaning. As Sandelowski (2000) concisely states, "all inquiry entails description, and all description entails interpretation" (p. 335). Personal subjectivity, and subsequent interpretation, is used to account for understanding experiences as well as understanding the experiences of others (Bourke, 2014). As clinicians use inquiry, description, and interpretation to conceptualize phenomena, it is important to look at the differences between Western and Eastern models of treatment.

Western models of mental health care do not capture other cultures' models of traditional healing (Sood, 2016) and at times the Western psychotherapeutic approach does not align with Eastern values (Ting, 2012). It is important that clinicians are mindful that there are other cultural models of healing (Ting, 2012). In addition, assuming that Western culture is superior to other cultures is considered a cultural trap that American psychologists may fall into (Glover & Friedman, 2012; Heppner, Wang, Heppner & Wing, 2012).

Meaning Differences between Clients and Clinicians

The literature suggests that religion and spirituality are highly regarded by religious and spiritual clients and less regarded by clinicians (Smolak, Gearing, Alanzo,

Baldwin, Harmon and McHugh, 2013). Discrepancies between the faith of the client and the faith of the therapist may or may not be a factor in clinical treatment (Hustoft, Hestad, Lien, Moller, & Danbolt, 2013). However, historically, there has been and continues to be a lack of balance between the nonreligious position of clinicians and the religious position of their clients (Delaney, Miller, & Bisono, 2013), as well as an anti-religious framework in the field of psychology (Vieten, Scammell, Pierce, Pilato, and Ammondson, et. al., 2016). Some clinicians' view of client religious and spiritual frameworks are referred to as "outmoded or backward worldviews" (Whitley, 2014, p. 255), as well as archaic (Sood, 2016). This may be seen as part of the "religiosity gap" between clinicians in nonfaith based frameworks and the general population reporting religious affiliation (Ng, 2009). The long-standing ambivalence aimed at religion and spirituality hinders client centered and recovery centered models (Whitley, 2014).

Currently, the main thrust of clinical psychological treatment is primarily directed on cognitive, biological, neurological and biological frameworks and lacks consistent attention on religious and spiritual themes (Delaney, Miller & Bisono, 2013; Sood, 2016) when they present in clinical practice.

While clinicians realize that religion and spirituality are important to the client, some do not integrate them into regular clinical care (Moreira-Almeida, Koenig, & Lucchetti, 2014). When clients do address religious and spiritual beliefs, the diagnostic variability to discount the religious and spiritual phenomena turns out to be "more the rule than the exception" (Post & Wade, 2009, p. 134). Whitley (2014) asserts a large number of mental health professionals ignore or pathologize religious and spiritual

features. Some mental health clinicians are lagging in their acceptance of religion and spirituality in practice and do not act in ways that support the inclusion of those cultural features (Whitley, 2014). This suggests that a clinician's distinguishing process may be affected by the familiarity or unfamiliarity of religious and spiritual cultural features.

Case Studies

In the extant literature, there are examples, case studies that show the process of distinguishing whether symptoms are psychotic or not among religiously and spiritually inclined persons. Relevant case studies explore the concept of a spiritually advanced person or person experiencing psychosis and a kundalini awakening versus a psychotic break. In two of these case studies, clients stated that the experience was part of a religious and spiritual experience (Bhargav, Jagnnathan, Raghuram, Srinivasan & Gangadhar, 2015; Valanciute & Thampy, 2011). The clinicians did not agree. The manner in which the clinicians arrived at their conclusion are examples of culturally competent, thorough, and ethical approaches to therapy. They are described in more detail below.

Case Study 1: Spiritually Advanced or Psychotic

Bhargav, Jagannathan, Raghuram, Srinivasan, and Gangadhar's (2015) analysis of the concept of a spiritually advanced personality was done to distinguish between features of spirituality and psychosis. The authors used ancient texts, the Bhagavad Gita and the Holy Bible, in combination with modern psychology, to support or contradict phenomena hovering over the line of pathology. They determined that while the client's words mirrored the text, the presentation and context of the material did not. It was not

the client's language, but the client's behaviors that helped them determine that the client was in fact experiencing psychosis. According to these authors, when the client presents with psychotic content with religious and spiritual features, clinicians must weigh the client's functioning, behaviors and activities of daily living (Bhargav, Jagnnathan, Raghuram, Srinivasan & Gangadhar, 2015).

Case Study 2: Spiritual Awakening or Psychotic Break

In another case, a client was admitted for care with the presentations of psychotic-like symptoms, substance use, religious symptoms, and decompensation in activities of daily living blurred (Valanciute & Thampy, 2011). Use of cannabis was determined to be a comorbid factor associated with psychosis. The client was diagnosed with a psychotic-related disorder. The client disagreed and reported experiencing a spiritual, specifically a kundalini, awakening. While in treatment, the client continued to search out information to support beliefs about the experience. Simultaneously, the client was entertaining that in addition to the spiritual experience mental health problems were also present. Once the client sustained an appropriate level of functioning he was discharged.

In review, there are intertwined aspects between religion and spirituality and the knowledge of the client's religious and spiritual history is invaluable in the diagnostic process (Mohr, et. al. 2010; Moreira-Alemida, Koenig, & Lucchetti, 2014). Clinicians must initiate conversations about religious and spiritual features, the role they play for the client, and the meaning that the client places upon the phenomena, especially if there are culture disparities between the clinician and the client. According to the literature review,

published studies that explore how clinicians interpret and address cultural phenomena are lacking.

Conclusion to the Literature Review

Discounting religious/spiritual phenomenal experiences as psychotic in current society limits the acceptance of uncommon and nonpsychotic phenomena. My goal was to address the delete tripartite relationship between religion/spirituality and psychosis. The literature points to a need for increased clinical understanding on how clinicians distinguish between what are religious/spiritual features that do not require a focus of treatment while exploring the role of religious/spiritual features that are psychotic in presentation. In delivering psychotherapy, the clinician would do well to be equipped with multicultural competence. My goal was to gain insight and understanding of the clinicians' process of distinguishing these symptoms as well as having key themes or terms to be mindful of in therapeutic practice. To move forward in the study a qualitative approach was used. The methods for this study are described in detail in Chapter 3.

Chapter 3: Research Method

Introduction

Murray, Cunningham and Price (2012) reported an experience with a client who was diagnosed with schizophrenia. The client stated that he had a supernatural mission from God. The client declined to take the psychotropic medication prescribed. When the team inquired into the medication decline, the client asked the clinicians, "How do you know the voices aren't real? How do you know I am not the Messiah? God and angels talked to people in the Bible" (p. 410). The client's questions to the clinicians drew attention to the actual diagnostic process when distinguishing between religious, spiritual, and psychotic phenomena. How *do* clinicians know the difference between what is real and what is unrealistic? After further reflection, the clinicians posed two questions:

> How do we explain to our patients that the psychotic symptoms are not supernatural imitations when our civilization recognizes similar phenomena in revered religious figures? On what basis do we distinguish between the experiences of psychiatric patients and those religious figures in history? (p. 410-411)

This example illustrates the need for accurate cultural exploration as the clinical foundation of treatment. It is important to know and understand how clinicians address complex diagnostic issues "with regard to the potential influence of confounding spirituality or beliefs" (Valanciute & Thampy, 2011, p. 841).

The purpose of this qualitative study was to explore how clinicians distinguish between pathological psychotic delusion and hallucination symptoms needing clinical

care and nonpathological cultural features relating to religion/spirituality. In this chapter, I describe the research method, including the design and rationale. I explain my role as the researcher and the procedures, such as participant selection, instrumentation, procedures for recruitment and participation. I include the interview I used. I detail the data collection and data analysis plan. Finally, I discuss issues of trustworthiness, credibility, transferability, dependability, and confirmability.

The measures for protection of participant rights are summarized as well as the ethical considerations for the study. The results of this study will contribute to the body of literature on the process that clinicians undergo when assessing clients for psychosis and psychotic-related disorders.

Research Questions

This study was based on two qualitative questions. The first question is followed by its interview questions:

RQ1. How do clinicians describe their understanding of clients' religious/spiritual experiences and beliefs as distinct symptoms from psychotic symptoms needing clinical care/treatment?

1. Describe your understanding of psychosis and if it has evolved over time.
2. How do you distinguish religious/spiritual phenomena from psychotic phenomena?
3. Think back and please describe 1-2 occurrences when religious/spiritual and psychotic phenomena were difficult to disentangle.

4. Describe a time when religion/spirituality presented as psychotic. If so, how did you distinguish?

5. Describe a time when psychosis presented as religious/spiritual If so, how did you distinguish?

6. Have you had a client who was experiencing psychosis and religious/spiritual phenomena simultaneously? If so, how did you distinguish?

Likewise, the second question is followed by its interview questions:

RQ2. How do clinicians engage in conversation and explore their clients' religious/spiritual experiences and beliefs and psychotic symptoms needing clinical care/treatment?

1. How do you start a dialogue w/ clients when exploring their religious/spiritual beliefs and experiences?

2. When a client presents with religion/spirituality that you are familiar/ unfamiliar with, how do you broach the subject?

3. What kind of conversations w/ clients have been the most fruitful when distinguishing religious/spiritual and psychotic phenomena? The least fruitful?

4. Have you ever not told a client the diagnostic decision to identify a religious/spiritual feature as psychosis? Why or why not?

5. Have you ever disagreed with a client relating to religion/spirituality as psychosis? If so, describe the process and outcome.

Research Design and Rationale

There are several qualitative designs that a researcher can select when conducting qualitative research such as a phenomenological design and case study. To address the questions for this study, a generic qualitative design was used. A quantitative research design was not chosen for this study due to its discrete categories. A generic qualitative study is more interpretive than quantitative research, as there are no preselected variables and there is more room for interpretation and attributing meaning of events (Sandelowski, 2000). The study provides more descriptive data through qualitative conversations with individuals rather than gaining statistical data through other quantitative methods.

A phenomenological research design was not be used due to the limitation that the approach would provide insight to the internal experience of the clinician, not the necessary "how to" distinguishing process that may be used through a generic approach for the study. The purpose of the study is not to explore and describe the inner experience of the clinician. The purpose of the study was to explore and describe the process of the clinical assessment when the content of the feature may be pathological or nonpathological. A case study design would not provide enough descriptive data to be considered significant for this topic. A generic qualitative framework is useful as it is flexible and open for data to emerge (Kahlke, 2014). The data emerges through generic qualitative description as it does not follow a specific school of thought and describes the data simply (Sandelowski, 2000).

The use of a generic qualitative framework is justified through its use of reflexive methodology as it operates in the moment, is personal, and seeks to understand how the

clinician is conceptualizing and understand the material presented by the client. A generic qualitative approach provided freedom within the framework to allow the data to speak freely. In the study, a generic qualitative research design operating in the moment assisted me through flexibility in asking questions for more descriptive depth. Another rationale for the chosen tradition of the generic qualitative approach is that it may be used to advance new theories (Kahlke, 2014).

A generic qualitative framework was useful for this study as there is no rank order of types of qualitative research (Sandelowski, 2000). Additionally, I sought out basic knowledge and understanding related to distinguishing religious/spiritual and psychotic phenomena. Basic, or generic, qualitative theory posits that it "entails a kind of interpretation that is low-inference or likely to result in easier consensus among researchers" (p. 335) as various clinicians may read a generic qualitative study yet pull different facets from it according to the description of the clinician. The author states that the facts of the study are accurate descriptions of the study; however, how the study is interpreted may vary across multiple types of clinicians with differing theoretical orientations, as previously mentioned. The generic qualitative framework was the most desirable for this study in seeking to understand the basics of how clinicians distinguish phenomena. The results from the study will contain noninferential data.

Role of the Researcher

As the primary researcher, my role was to conduct the qualitative research study from initial development through analysis and interpretation. I was the only interviewer and observer. I interviewed the participant with a semistructured interview with open-

ended questions to allow for maximum flexibility to gain data. I observed and noted nonverbal movements and other nonauditory aspects. I wrote additional memo notes to support the audio data. I did not have current relationships of any sort with the research participants. I used $10 Starbucks Coffee gift cards as an incentive to participate in the study. The use of this incentive falls within reason in ethical standards.

As the primary researcher, and as the primary research instrument, I did not have any personal and professional relationships and I did not have any supervisory instructional powers. I am a licensed clinical mental health counselor and I have direct and indirect experience with the process of distinguishing between religious/spiritual and psychotic phenomena. As the phenomena of religious/spiritual and psychotic features overlap and are complicated to distinguish, I recognize that many clinicians have experienced difficulties when distinguishing between the phenomena. To reduce bias, I was aware of what I already have experience with and I was mindful to explore areas of distinguishing religious/spiritual and psychotic phenomena that I am not familiar with.

To manage researcher bias, I used journaling to record my thoughts and ideas to understand the bias better and reduce assumptions. Using a reflective journal assisted in sharpening my self-awareness and assisted me to articulate meaning and understanding (Janesick, 2011). The detailed descriptions that emerged through reflective journaling supported credibility in what Shenton (2016) referred to as “thick description of the phenomenon under scrutiny” (p. 69).

In addition to myself as the primary researcher, my co-researchers, my Chair and second chair member, assisted in in their roles to manage bias. I was in frequent contact

with my Chair and second chair member reviewing concepts and ideas as well as how to develop and implement the data collection and data analysis protocols.

Methodology

Participants and Sampling Strategy

I needed up to 12 licensed mental health professionals in the U.S. for the study. The invited participants for the study were psychiatrists, psychologists, mental health counselors, and social workers. These participants were sampled through criterion sampling. This type of sampling suits well as I sought participants who met the specific criterion: the clinician must have gone through the distinguishing process between religious/spiritual and psychotic phenomena. The participants identified above would likely complete this diagnostic task in clinical internships and practicums. Strength of using criterion sampling is that it provided the latitude to obtain information rich cases.

In addition to using criterion sampling to recruit for potential participants, snowball sampling was also used. Snowball sampling happened through the use of liking and sharing flyer posts on social media. Criterion and snowball sampling assisted me in gaining access to potential clinicians through professional networks through social media. This aligned well with the generic qualitative framework.

Sampling Demographics

The inclusion demographic criteria for the study participants were (a) that the professional role the clinician currently practices is as a licensed mental health professional; and (b) if the participant had personally gone through the process of distinguishing between religious/spiritual and psychotic phenomena. In addition, the

participant must be able speak English fluently, as I do not speak any other language. The demographics form includes the age, gender, years of experience in working in the mental health field, title and degree, current position and role, and clinical population and specialization. See Appendix A and Appendix B.

Demographics

In this study there were nine female (90%) and one male (10%) participants (n = 10). The ages of the participants of this study ranged from 28 to 66 with a mean age of 43.55. No licensed psychologists and psychiatrists participated in the study. All participants' clinical populations included adults. All participants were from the United States. Table 1 presents the demographic characteristics of the 10 participants. The demographics of the participants are as follows: participant identification number, age, gender, years of experience in mental health, title/degree, current position, and clinical population specialization.

Table 1

Participant Demographics

Participant	Age	Gender	Years of MH experience	Title and Degree	Current position	Clinical population
RSP1	66	Female	10	LMFT, MA	Psychology associate incarceration	Adult women
RSP2	63.5	Female	7.5	LMHC, PhD	Private practice	Adults and children
RSP3	57	Female	5	LMHCA, MA	Private practice and community mental health	Adults, families, children
RSP4	38	Female	3.5	LSWAIC, MSW	Private practice	Adults
RSP5	47	Male	5	LSWAIC, MSW	Private practice	Adults
RSP6	29	Female	2	LPCA, MA	Private practice	Adults and children
RSP7	46	Female	>1	LPC, MA	Nonprofit agency	Adults, women, and children over 7 years old
RSP8	28	Female	7	LSWAIC, MSW	Mental health therapist	Adults
RSP9	29	Female	5	LMHC, MA	Staff clinician	Adults
RSP10	32	Female	5	LMFTA, MA	Community mental health	Adults

Recruitment

After obtaining IRB approval from Walden University, social media sites Facebook and LinkedIn were the venues used for the recruitment of participants. The IRB approval number was 06-28-19-0574071. I posted the recruitment post (Appendix C) on my personal Facebook page and LinkedIn page and in formal and informal membership and network pages on Facebook. I attempted snowball sampling. I was contacted by friends and network members informing me they intended to share my recruitment with their friends and networks. I recruited zero participants through LinkedIn, eight participants through Facebook, and two participants through snowball sampling. I did not have any personal and professional relationships with any of the participants.

Instrumentation

I used an open-ended, semistructured interview. A semistructured interview was desirable to obtain the information that this I sought to discover. Strength of the semistructured interview was that the questions were tailored to delve more deeply in the topic. Interviews lasted 30-90 minutes. They were digitally audiorecorded, transcribed verbatim, and along with my field notes, were used to capture components and interactions that were inaudible. The interview was designed to be an appropriate venue to describe clinician's process of how they distinguish between religious/spiritual and psychotic symptoms. The interview questions are in Appendix D.

Development of the Instrument

Religion and spirituality are personal and often described as deep and that the thoughts and feelings related to spiritual things are "often too deep for words" (Blazer,

2009, p. 282). This supported using qualitative semistructured interviews to explore current language and key themes used to describe religious/spiritual phenomena. The semistructured interview helped to reflect the complexity of distinguishing religious/spiritual and psychotic phenomena. The interview questions were designed to capture specific words and themes that clinicians' use to understand the specific words and themes used by clients to describe religious/spiritual and psychotic phenomena

I developed the semistructured interview to explore how clinicians understand and how they engage in conversations with clients about religious/spiritual and psychotic phenomena. I am a licensed mental health counselor (LMHC) in Washington State and have extensive experience in providing mental health assessments and evaluations. I have used my personal experience and have reflected back upon questions that are beneficial when exploring cultural and pathological features. I broke down the two main questions into 5 sub-questions exploring their clinical distinguishing processes, giving examples of phenomena that were difficult to distinguish between, and what kind of language and communication helped or hindered diagnostic clarity. The semistructured interview was designed to focus specifically on cases exploring how the clinician understood and distinguished between the reported religious/spiritual and psychotic phenomena.

I designed two research questions to explore the diagnostic process that clinicians use. The participants invited to participate in this study were licensed psychologists, psychiatrists, mental health professionals, and social workers. Using a semistructured interview, I developed questions exploring clinician understanding of the differences

between religious/spiritual and psychotic phenomena and how clinicians speak about this topic with their clients.

Data Collection

The initial intent for this study was to interview up to 12 licensed mental health professionals in Washington State. Potential participants were to be psychiatrists, psychologists, licensed mental health counselors, and licensed marriage and family therapists. However, I received immediate and significant responses from social workers and licensed mental health associates interested in the study and asking to participate. In addition, I also received significant response rates from potential participants in other States other than Washington State as well as a couple from countries outside of the United States of America. This interest provoked me to seek chair counsel to broaden the scope of participants. After discussion and collaboration with my chair, I completed IRB/Ethics amendment forms and followed Walden University protocol to broaden the participant parameters to include social workers and licensed mental health associates in all of the United States of America and recruited the appropriate participants.

Once a potential participant contacted me through secure messaging through Facebook and a secure email system through Walden University we moved forward in the data collection steps. Through messaging and email correspondence with the participants, I ensured eligibility through screening (Appendix A), sent and received the demographic form (Appendix B) and sent and received the Informed Consent form. Through email I instructed the participants to complete the demographic form and return the informed consent back to me with the written words, “I consent” in the reply. I

requested specific days and times that the participant was available for the face-to-face or phone interview and flexed my schedule to accommodate theirs. I printed copies of the email correspondence, including the demographic and informed consent forms, for the research hard copy confidential file. The scheduled interviews were to last between 30 and 90 minutes in length.

The participant and I met either face-to-face in their clinical office or a private room in a public library or on the phone at the agreed upon time. Before starting the interview, I reviewed and confirmed that the screening instrument, the demographic form, and the informed consent were correct and aligned with the study. When arriving at a clinician's office I identified myself by name only for privacy sake. When using a library to conduct the interview, I reserved a private room and waited by the front door of the library room for the participant to approach me. For those who were not able to meet for a face-to-face interview, phone interviews were used. I ensured privacy by being the only one in a closed room. Through these avenues I was assuring privacy and confidentiality.

During the face-to-face interviews the participant and I sat directly across from each other. In some interviews there were desks and tables between us and in others there was nothing between the participant and myself. In all of the interviews I used two digital recorders, one with an extra microphone, to capture the interview. I also kept a portfolio folder in front of me with a copy of the semistructured interview questions and a memo pad for writing notes and identifying initial codes.

The semistructured interview proved to be too dichotomous for the first few participants. I stopped using either/or style questions and used more open ended questions and scenarios. Sample semistructured questions included: “How do you distinguish religious/spiritual phenomena from psychotic phenomena?” and “Describe a time when psychosis presented as religious/spiritual. If so, how did you distinguish?” I found that I had to adjust my language and the questions to collect the data when exploring clinicians’ distinguishing process when exploring religious/spiritual and psychotic phenomena. I shortened the questions for the following participants to process the questions without asking for a response that categorized the phenomena in clear and distinct categories.

At the close of each interview, I thanked the participant, informed them they would receive a three to four page summary of the themes of the study via email after all interviews were completed and transcribed, and gave them the $10 Starbucks card incentive. After the interviews were completed I uploaded the digital files to Rev.com for transcription service for my data analysis.

Analytical Strategies

I used a transcription company for each individual interview that I captured digitally. I had a confidentiality agreement between the transcription company and myself. I hand coded, digitally coded, and analyzed each recorded individual interview to explore themes and subthemes related to the distinguishing process when exploring religious, spiritual, and psychotic phenomena. I reviewed the material multiple times to gain an understanding of the participant responses. I compared and contrasted the audio

output, the written transcribed data, and the field notes captured at the time of the interview. I compiled the qualitative data into themes and subthemes. Participant names were coded during data collection and storage to maximize confidentiality. The hard copy files are stored in a locked cabinet and electronic files are password protected.

The framework for the study is generic qualitative and as there is no specific qualitative approach, such as a case study or phenomenological study, there is flexibility in the analysis of the study. I viewed the data through a data analysis spiral and then examined the data through thematic analysis. The data analysis spiral allowed for organic movement through "analytic circles" (Creswell, 2013, p. 182). The author asserts that qualitative researchers "preserve the unusual and serendipitous" (p. 182) which was captured through the use of thematic analysis in the study.

Using data analysis spirals provided a vantage point to view multiple themes and subthemes simultaneously. This, in turn, assisted me as I used thematic analysis to organize and code the data. In the qualitative search for themes and patterns thematic analysis was an appropriate framework. Thematic analysis is a foundational and basic form of qualitative research that may be used in a variety of research contexts (Braun & Clarke, 2006). The authors assert thematic analysis is flexible and may be broadly applied. As thematic analysis is flexible, the individual using the method of analyzing the data needs to be cognizant to not stretch it pasts its ability to be identified. I followed these instructions when I used thematic analysis.

I used thematic analysis to focus on the meaning and importance of the phenomena of interest across the set of clinicians participating in the study. By exploring

the emerging themes and subthemes related to religious/spiritual and psychotic phenomena I was able to identify what is common to the population (Braun & Clarke, 2012). I hand coded to define and name themes. I clarified specific language and terms that clinicians used to describe their process. I noted what was unique about their process through singular concise themes, related themes, and what were directly connected to my two research questions (Braun & Clarke, 2012).

Features of interest for the study are what Braun and Clarke (2012) refer to as inductive approach or bottom-up approach and experiential themes. The aim of the study was to explore the "how to" process that clinicians go through when distinguishing between religious/spiritual and psychotic phenomena. Using the inductive approach fit well as I looked at how the clinician builds the clinical conceptualization warranting a psychotic disorder or if the phenomena is cultural and not in need of clinical treatment. In addition, the focus on experience was embedded within the research questions. The study aimed to discuss personal clinical experiences.

Braun and Clarke (2012) assert that the more familiar that the analysist has relating to the subject of interest the more likely they will "have deeper insights" (p. 60). This is strength as I have frequently worked with individuals experiencing psychosis and psychotic-related disorders. Following the authors guidance, I was involved in an extensive process of review and re-reviewing the data for language and word patterns developing into themes and subthemes.

Another benefit of using thematic analysis in the study was its attention towards epistemological and ontological aspects (Clarke, 2018). I sought to explore the how-to

process that clinicians go through when distinguishing religious and spiritual and psychotic phenomena I examined the epistemological aspect of knowledge and how learning is applied manifesting in behaviors resulting from beliefs and opinions. In addition, the ontological aspects of the nature of being and relationships within were valuable to the study. Thematic analysis aligned well for the study in exploring the phenomena of how clinicians distinguish between religious, spiritual, and psychotic phenomena.

Evidence of Trustworthiness

Trustworthiness is synonymous with honesty, being truthful, and reliable. One aspect of trustworthiness is that the more time the researcher has spent in focused observation on the topic of interest, the more credibility is added (Patton, 2015). I am a licensed mental health therapist and I have spent extended periods of time focused on the phenomena of interest, distinguishing religious/spiritual and psychotic phenomena. According to Shenton (2016) the familiarity I have relating to the clinical mental health environment in which the data collection occurred is a technique of trustworthiness.

Using the technique of encouraging honest and direct dialogue as well as asserting that there is no right or wrong response (Shenton, 2016) will add to the trustworthiness. I have therapeutic skills to develop rapport and create an environment of safe disclosure. I reassured participants that their responses were confidential and no one other than me will have access to the data.

Transferability

In quantitative studies, generalization applies to how individuals and groups may receive similar interventions. In qualitative research, transferability entails "the particular description and themes developed in context of a specific site" (Creswell, 2009, p. 193), and also known as external validity. Through the use of thick rich description, I increased validity by providing detailed descriptions about how clinicians distinguish between religion/spirituality and psychosis. From reading the thick rich descriptions, the reader is provided enough description to establish similarities and transfer the findings (Patton, 2015) in clinical settings. The boundaries of the study were clear in whom the targeted population was and the specific phenomena, religious/spiritual and psychotic phenomena to be explored. I clearly stated the boundaries for the study in the limitations, delimitations, how the data will be collected including the time and length related to participant interviews to strengthen transferability (Shenton, 2016).

Dependability

Dependability, also known as reliability in quantitative research designs, may be known as how well the researcher tracks data throughout the research process. In the study I used audit trails to document the process of data collection. I kept detailed notes from the initial contact through transcription agreement. These notes included my feelings, reactions, personal meanings, interpretations, insights, and intuitions (Patton, 2015) relating to the topic of study, distinguishing religious/spiritual and psychotic phenomena.

Shenton (2016) proposes that a well detailed and clearly outlined research process may increase dependability and may be viewed as a "prototype model" (p. 71). The study addresses a gap in the "how to" process that clinicians experience when distinguishing religious/spiritual and psychotic features. Through the use of Shenton's (2016) trustworthiness strategies, the study may be viewed as a prototype model in exploring the clinical task of distinguishing between phenomena and symptoms.

Confirmability

Confirmability also referred to as objectivity, was seen through the strategy of reflexivity. Reflexivity was used to show both the internal thoughts and feelings I had during the data collection process and the external thoughts and beliefs given by the participants in (Palaganas, Sanchez, Molintas, & Caritivo, 2017). Patton (2015) posed three interconnected reflexive questions while conducting research: How do I know what I know? How do they know what they know? How do they make sense of what I give them? I kept these questions in mind and journaled notes when appropriate.

Ethical Procedures

Ethics must be on the forefront of every research study as the rights of the participant are not to be violated and dignity of the person must be carefully considered. To maintain required ethical standards, I completed the training, "Protecting Human Research Participants Online Training" in preparation for the study and was given a certification number as required by Walden University. I submitted an Institutional Review Board (IRB) application which included the specific steps and ethical considerations I took when conducting the proposal. I only collected data after I received

approval from Walden University IRB. After approval from the IRB and participants were screened, I provided Informed consent.

Informed consent provided the potential participant necessary information in order to make the decision to participate or decline to participate in the study (Bersoff, 2014). The decision to participate in the research was held by the participant, who may have chosen to leave the study at any time for any reason without penalty. I provided Informed Consent to participants who read and signed prior to participating in the interview. The informed consent included the risks and benefits to participating in the study. For the study, the risks were considered as no more severe than daily life stressors. The study should not pose risk to the safety and wellbeing of the potential participant. A benefit of the study was expanding the limited research on the how-to distinguishing process clinicians go through when addressing religious/spiritual and psychotic phenomena.

Additional ethical considerations for the study were confidentiality and privacy, securing and storing interview data, and the risks and benefits for participating in the study (Bersoff, 2014). The participant's identity was not shared and personal identifiers were not collected. In addition, reports emerging from this study were not shared. Participants were assigned a number such as RSP1, RSP2, etc. and I was the only one collecting and analyzing the data. Data was stored on a secure flash drive in a locked cabinet.

Notably, an ethical consideration is to control bias for myself as the primary researcher. To address this consideration, I used journaling, memoing, and close

oversight by my chair. I used supervision feedback and journaling to control bias and allow for new and alternative ideas to emerge. Through this process I was able to engage in nonjudgmental practice and refrain from over interpretation, under interpretation, and inappropriate interpretation (Bersoff, 2014).

Summary

Chapter 3 focused on the methodological process of the study. The goal of the study was to address the gap in the literature relating to the distinguishing process between religious/spiritual and psychotic phenomena. I chose to use a generic qualitative framework for the study. Using a generic qualitative framework and using thematic analysis was desirable as in conjunction they provided wide latitude to explore the phenomena as well as flexibility for the themes to emerge. As the primary researcher, I explained the strategy of reflective journaling to reduce bias and provoke me to follow data paths I would typically not take. I sought up to 12 mental health professionals in the U.S. to participate in the study. I used social media to recruit for participants. When participants qualified and were screened, data collection through the use of a semi-structured interview that I developed to interview potential participants occurred. I used thematic analysis to allow themes and subthemes to emerge. In this chapter, I provided evidence of trustworthiness and addressed transferability, dependability, and confirmability. I closed the chapter with an ethical overview of the study.

Chapter 4: Research Results

Introduction

The purpose of this generic qualitative study was to describe the "how-to" process that clinicians use when distinguishing between religious/spiritual and psychotic phenomena. In the study, I explored the overlap between religion/spirituality and psychosis; it was not to explore the nonpathological presentation of religious/spiritual phenomena and the obvious and extreme presentations of psychosis. In Chapter 4, I include an overview of the data analysis, evidence of trustworthiness, and the results.

Data Analysis

Prior to the interviews, I contacted a transcription service; Rev.com, to transcribe the interviews for this research. Rev.com signed and returned a confidentiality notice as part of a nondisclosure agreement prior to using the service. Each participant was given a pseudonym, Research Study Participant 1 (RSP1) through Research Study Participant 10 (RSP10). I uploaded the digitally recorded interviews to Rev.com and within 48 hours I was able to download the transcribed interviews through secure servers and secure email. After downloading the transcripts, I saved them in a password-protected file. I printed the transcripts and used the hard copy to hand code and analyze the data. I listened to the digital recording while reading along with the transcript to ensure accuracy. I indicated, through handwritten notes and symbols, thematic material relevant to the research questions and purpose of the study. I revisited material where I noted a personal emotional reaction and interpretation, and communicated with my chair for feedback, accountability, and as an effort to provide clean data.

I created field notes *during* the interviews and I created memos *after* the interviews. The field notes reflected the nonverbal presentation of the participant as well as statements that resonated with me and made me want to ask more questions. The field notes were used as a tool to set aside personal biases. I used memos to summarize my mental state and describe my cognitive activity during data analysis and the evolving interpretations I had about my data. Memos contained initial thoughts on data analysis including codes, categories and their relationships, and similar content that I discussed in the literature review.

In addition to hand coding, I used digital coding. Digital coding included transferring my hand written notes into codebooks which were organized into distinct families of codes and participant dictionaries. Throughout this process, my chair helped me with Saldana's (2006) instruction on the personal attributes needed for coding: organized, persevering, able to deal with ambiguity, flexible, and creative. My chair and I discussed the insights, ideas, and concepts that arose in the data analysis process. This process was instrumental in how the insights, ideas, and concepts contributed to creating codes and themes. The collaboration with my chair helped me appropriately code participants' quotes and to organize the reported cultural and clinical phenomena so that themes evolved. The two analytical methods, hand coding and digital coding, yielded a holistic analysis of the participants' "how to" process when distinguishing among religious, spiritual, and cultural phenomena.

I did not use deductive coding, which includes preset codes, themes, and categories to provide a certain direction in my analysis. Instead, I used inductive coding

within thematic analysis. As thematic analysis is an iterative and organic process I searched for commonalities within the coded themes. Thematic analysis was used to report themes and connect concepts as well as relationships within codes. The data was reduced through physical and conceptual reduction of the data. Thematic analysis was also used in breaking the codes into common language to thick qualitative description. Descriptive theme content was used to report meaning.

I hand coded and digitally coded the transcripts using thematic analysis. Through hand coding I used highlighters, pens, pencils, and post-it notes. Through digital coding I coded line by line and focused coded the transcripts. I would compare the hand coded and digital coded material constantly through data analysis. Through this process I was able to refine the codes to concisely describe key concepts and themes that the interviewed participants had in common.

In the digital coding line by line codes were designated as central organizing concepts and focus codes were designated as domain summaries. I took advantage of the flexibility of a generic qualitative framework and used the technique of a "central organizing concept" (COC; Clarke, 2017) for the line by line codes. The COC explores the shared meaning, the implicit under the surface meaning, and the secular and religious ideas of influence. Using line by line coding assisted me to analyze the data critically and introspectively instead of becoming immersed into the participant's worldview (Charmaz, 2004). Using line by line codes as a COC was important as the participants were providing the context and content definitions of the thematic material that eventually became the participant dictionary.

The data analysis process using domain summaries to accurately identify and reflect themes worked well in this study. Domain summaries, as described by Clarke (2017), are reflective of the data collection and were used as a topical summary. Domain summaries were organized to create and use a participant dictionary. In the participant dictionary I defined the voice and context of the participant's responses to the semi-structured interview questions. The participant dictionary developed into thematic family groupings. The family groupings developed into fully realized themes. A sample of the transcription codebook is shown in Table 2. I chose this sample as it shows the depth of the analysis of the interview transcription and shows the focused attention to language, culture, and worldview within a clinical context. This sample of the transcription codebook illustrates how I was organizing and conceptualizing the data and creating fully realized themes.

Fully realized themes, as described by Clarke (2017), are interpretive and creative data that reads like a story book. By using fully realized themes I was able to explore and meditate on the underlying patterns, concepts, and ideas within the data that was identified when I used domain summaries. Using fully realized themes provided deep and descriptive analysis. The fully realized themes tell a story of clinician's perspectives when distinguishing between religious/spiritual and psychotic phenomena.

Table 2

Example of Transcription Code Book

Transcription	Line by Line Coding	Code
Yeah, and it would definitely be perceptions. Obviously this is not a topic that's cut and dry, I don't think for anyone. I think it's more common, in my experience, that when someone's in psychosis, they are feeling tormented, feeling more of a demonic feel to it. I work in a Christian agency, so the people that come to me know that we're Christian, so they're going to be thinking along those lines to begin with, knowing that I might pray for them or something like that, like separate from the actual counseling.	Perceptions differ Not cut and dry; not either/or Psychosis is tormenting, demonic She works with those who share the same worldview in her practice Spiritual and clinical differences	Perceptions differ Not cut/dry, either/or Language to describe psychosis as rs, demons Same worldview Clinical and cultural differences
When someone is feeling demonically tormented and think they're seeing ghosts or think they're seeing … just feeling a sense of evil, it is hard to differentiate between psychosis and reality. I am, in my perception, in my beliefs, I believe there's good, so that means there has to be evil as well in the world. But from a professional standpoint, we cannot go back to the dark ages where we blamed everything on demonic influences. We cannot do that. It wasn't real, but I tend to believe that sometimes even psychosis can have a little teeny tiny hint of demonic influence. Does that make sense	Demonically tormenting, seeing ghosts, sensing evil – that is hard to differentiate between psychosis and reality. Her personal worldview/perception allows for good and evil; clinically going back to the dark ages and blaming all things on demons is not ideal. Psychosis can have demonic influence.	Language to describe rs as demonic Hard to distinguish Worldivew allows for rs phenomena Worldview that does not blame everything on a phenomena Psychosis can have demons

Through viewing the transcripts and notes I was able to process the data simultaneously, compare and contrast codes and themes, and connect similar statements, ideas, and concepts. I was able to draw out clarifying themes and subthemes and organize them into commonalities and connectivity. Data emerged through the development of themes through domain summaries and fully realized themes actively created by myself (Clarke, 2017). I followed this process. By using these techniques, I was able to analyze the data to describe the perspectives that clinicians have when distinguishing between religious, spiritual, and psychotic phenomena.

To keep the data organized, I created one large digital codebook to capture the frequencies of the codes of the data that were used to create themes from all of the interviews. To maintain consistency, I kept the same format I used when creating the transcription codebook. The theme codebook has three columns: one to show the theme, one column to show the frequency the theme appeared in the data, and one column to show the interviews in which the theme appeared. A sample of the theme codebook is listed in Table 3.

Table 3

Sample of Theme Code Book

Theme	Number of times code appeared in data	Interviews in which theme appeared
TRAUMA: This overarching theme refers to trauma as similar to and overlaps with religious, spiritual, and psychotic phenomena.	103	RSP1, RSP2, RSP3, RSP4, RSP5, RSP6, RSP7, RSP8, RSP10

After creating the comprehensive codebooks, I pondered the themes that were similar to the participants and themes that were meaningful to the individual participant. By gathering similar themes and comparing and contrasting them to one another I was able to generate major themes and subthemes.

Themes from the Data

The interviews with participants were multilayered and provided insight on the perspectives of understanding the differences and similarities between religious/spiritual and psychotic content as well as the factors clinicians keep in mind when distinguishing between mental health symptoms and cultural phenomena. Participants were eager and willing to answer this study's research questions and three themes were created from their responses.

The first fully realized theme was created as *trauma is an important consideration when exploring religious, spiritual, and psychotic phenomena*. Participants reported trauma as overlapping psychosis and underlying psychosis. The second fully realized theme created from this data was *clinical experience is multifaceted*. Central organizing concepts developed from the interview data was that strict dichotomy and holding an either/or position is not appropriate, that there are obvious clinical features of distinguishing religious/spiritual and psychotic phenomena, and that the personal experiences and worldview of the clinician are important. The third fully realized theme is that *similar language is used to describe religious/spiritual and psychotic phenomena*. Central organizing concepts are the similarity and overlap of the language, that culture

must be considered, and features of clinical conversations that contain process and content are valuable to the distinguishing process. These themes are shown in Figure 1.

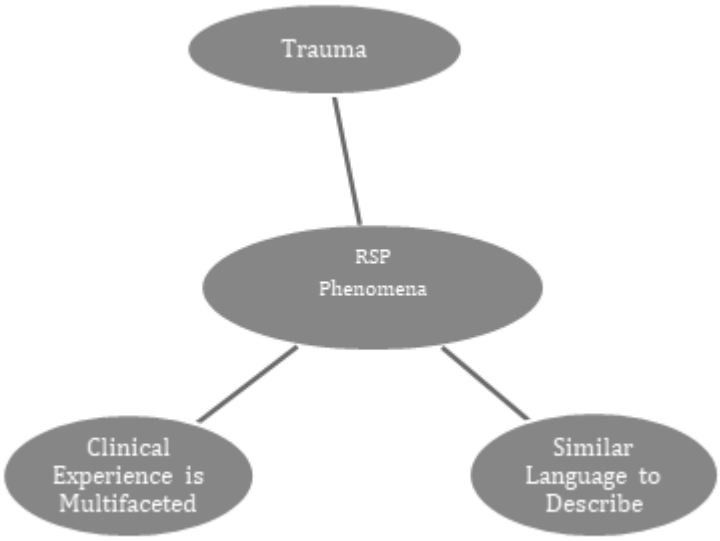

Figure 1. Three themes created from the data.

Monitoring my Reactions

Currently, I am a licensed mental health counselor (LMHC) practicing mental health in Washington State. I have been a professional mental health therapist for 7 years. I have served in multiple roles within religious/spiritual groups and communities for 19 years. I am a clinician who has experienced distinguishing religious/spiritual and psychotic phenomena. I monitored my reactions based on my clinical knowledge. I did not ask questions that would fall within a peer or supervisory scope such as addressing transference and countertransference and challenge the participants' clinical conceptualizations. During the interview I would often verbally summarize the participant responses and ask if I understood their clinical conceptualizations correctly.

As I am a member of the profession being studied and a psychology student researcher it was imperative that I remain within ethical boundaries as a student researcher. This process entailed that I did not ask questions that would fall within the consultative scope that clinical colleagues and peers would have. I also set aside my following presumptions:

- Psychosis and psychotic-related behavior has roots in religious/spiritual experiences, beliefs and behaviors.
- Clinicians believe that religious/spiritual transcendent experiences occur, but they do not feel comfortable talking about them with colleagues and peers.
- Some clinicians do not ascribe meaningful value to the religious/spiritual experiences of the client and thus deny the legitimacy of their belief.
- Clinicians do not have religious/spiritual knowledge of community networks needed to provide religious/spiritual interventions.
- Clinicians primarily treat psychosis through biomedical and neurological treatments.

Evidence of Trustworthiness

As a support to trustworthiness and confirmability, I attempted set aside my religious/spiritual worldview and intentionally asked and referred to diverse religious/spiritual phenomena (Mueller, 2012). I currently identify as a Charismatic Christian; however, I have a personal history of practicing Atheism, Catholicism, New Age, and Paganism. My family has practiced and is practicing Agnosticism, Catholicism, Christianity, Jehovah's Witness, New Age, Paganism, and Wiccan. I realize that my

substantial understanding of religious/spiritual phenomena is a strength as well as a potential bias and that it may have unintentionally influenced the probing questions and flow of the interview.

Etic, the position of the observer, and emic, the position of the subject being observed, perspectives are a part of positionality and may be considered as objective and subjective viewpoints (Bourke. 2014). While my experience may have factored into the interview itself, my positionality of personal and professional multicultural immersion relating to religion/spirituality was strength as it provided a common language and understanding of the phenomena discussed. Following the steps of (Mueller, 2012), I created a memo once the interview closed that included my impressions, additional thoughts, questions, and how to improve the interview. The author asserted that "checkpoints" (p. 1) in the reflective process of positionality are important in data collection and data analysis. This self-scrutiny (Bourke, 2014) provoked me to reflexively explore my concept of positionality and how I understood the interview process, interview questions, and probes with different perspectives.

Bourke (2014) found that personal proximity and interpersonal interactions impact the researcher and the participant. I found this to be true in my research as when I was interviewing more culturally aware participants I was more relaxed and open to give various examples to communicate the phenomena of exploration. I adopted Bourke's (2014) reflexive questions into the memo and journaling process. I asked myself the following questions: What role did my positionality as a multireligious and multi-spiritual individual play on the study? How did I use my positionality in different spaces?

And did my positionality influence the interactions I had with participants? (Bourke, 2014, p. 2). Just as my interview questions weaved with each other, these questions weaved in my memoing and journaling helped to guide my positionality awareness.

A benefit of my personal and professional experiences is that I have spent considerable time observing religious/spiritual and psychotic phenomena. This added to the trustworthiness of the study. In addition to the focused time observing phenomena as a technique of trustworthiness, transferability, dependability, and confirmability were also included in the qualitative study.

Transferability

Transferability in qualitative research refers to external validity (Creswell, 2009) so as to be able to replicate the study through the use of detailed description. Transferability was achieved through thick description. I used several meaningful vignettes to illustrate participants' perspectives. Transferability was achieved through noting phrases and words that clinicians agreed upon when evaluating phenomena that included religious/spiritual and psychotic in phenomena. Through the rich description described in Chapter 3, I have provided substantial religious/spiritual and psychotic content in context that may be transferable to similar mental health clinicians and the clients they serve.

Dependability

Dependability is similar to reliability in quantitative research. Dependability was demonstrated through the use of notes and journal entries throughout the progression of this study. These notes included my personal and professional feelings, beliefs, and

experiences. This may increase in dependability through Shenton's (2016) description of well detailed research as a "prototype model" (p. 71). This correlates with the literature review discussion in that there is little research on the "how-to" process that clinicians use when distinguishing between religious/spiritual and psychotic phenomena.

Confirmability

Confirmability refers to the researcher's findings reflecting the participants' data and not the personal biases of the researcher (Coa, 2007). Confirmability was demonstrated through objectivity and through reflexivity. I primarily followed Braun and Clarke's (Braun & Clarke, 2006; Braun & Clarke, 2012; Clarke, 2017; Clarke, 2018; Clarke & Braun, 2018) reflexive analytic process to guide me in this study. In learning their qualitative research framework specific to thematic analysis with a reflexive approach, I attempted to maintain faithfulness to their method rather than combine different types of thematic procedures and underlying philosophies. I meditated and reflected on my notes, the audio file of the interview, and the hard copy of the transcript. I followed Patton's (2015) reflexive questions: How do I know what I know? How do they know what they know? How do they make sense of what I give them? I kept a handwritten journal noting my thought processes and responses to the material that the participants were providing. This venue of confirmability provided me multiple opportunities to revisit the material and ponder the material at a deeper level which contributed to the thick and rich descriptions of the fully actualized themes.

Study Results

This generic qualitative research study using thematic analysis was to understand clinicians' distinguishing process when exploring religious/spiritual and psychotic phenomena. The semistructured interview allowed me to adjust my language in order to delve more deeply in the content of the participants' responses. I used my experience as a psychiatric interviewer, to match responses to questions and collaborate with the participant in finding meaning and understanding the semistructured interview questions. These research questions were answered through domain summaries, central organizing concepts, and the creation of three fully realized themes which are depicted in Table 4.

Table 4

Fully Realized Themes, Central Organizing Concepts, and Domain Summaries Derived from the Data

Fully realized theme	Central organizing concept (COC)	Domain summary
Theme 1: Trauma is an important consideration when exploring religious/spiritual and psychotic phenomena	a) Trauma overlaps with psychosis b) Trauma underlies psychosis	Trauma overlap Underlying trauma
Theme 2: Clinical experience is multifaceted.	a) Not either/or b) Obvious clinical features c) Personal experience and worldview	Not either/or Clinical psychosis Personal experience and worldview
Theme 3: Similar language is used to describe religious/spiritual and psychotic phenomena	a) RSP language overlaps b) Cultural considerations c) Clinical conversations	RSP language is similar Culture Process and content of clinical conversations

Theme 1: Trauma is an important consideration when exploring religious/spiritual and psychotic phenomena

In this study, I sought to explore how clinicians distinguish between religious/spiritual and psychotic phenomena. I specifically focused on religious/spiritual content that may overlap with psychosis. I did not expect participants to stress the theme of trauma and the role that trauma plays when distinguishing between symptoms and phenomena, which became the first fully realized theme. While trauma was not included as one of the phenomena of distinction between religious/spiritual and psychotic phenomena in the research questions, trauma was initiated and discussed by most participants.

Trauma is an important consideration when exploring religious/spiritual phenomena. The trauma theme was immediately obvious as eight consecutive participants reported that trauma is significant and important. Nine of the 10 participants reported they consider trauma when religious/spiritual and psychotic content are present. RSP6 summarizes the challenge of distinguishing trauma and psychosis symptoms as well as exploring the client meaning and the clinician meaning:

> RSP6: Then the other thing, I think, that comes to mind that's hard to leave out of the topic is trauma. A lot of the survivors that I worked with on the domestic violence response team, there was really extensive trauma history, and then sometimes there would be these symptoms that could feel psychotic. Even just the crossover there could feel confusing for me, confusing for them. The feeling for them of, am I crazy? Why is my body reacting in this way?

In this study, 90% of the participants reported addressing some features and symptoms of trauma as overlapping and independent of psychosis. The participants described trauma and psychotic symptoms as difficult to distinguish as they overlap. The second central organizing concept was that trauma underlies psychosis and its domain summary was underlying psychosis.

Trauma Overlap. Participants described *trauma as overlapping* with psychosis and other mental health disorders and difficult to distinguish. Dissociation related to trauma was referred to by nine of the participants. RSP2 and RSP6 reported dissociative symptoms may manifest as disintegrated selves which may appear psychotic. RSP4 noted that disorganized behavior linked to dissociative states and dissociative symptoms may be accounted for by trauma. RSP6 reported that trauma and dissociation may appear delusional as the symptoms of trauma takes the person out of the present moment back into the past and time and memory may be altered. The trauma and dissociation time distortion presents through flashbacks, intrusive memories, and increased hyper arousal which may be attributed to psychosis.

> RSP6: I think that the predominant lens that I work from is the lens of trauma, and that our bodies remember, and our bodies re-experience moments that were a big deal. Trying to understand what it's rooted in, and that that was a really real experience now, but what trauma does in, I guess, the present moment, it feels like it rips us away from the present and back to that past moment or that past relationship, to cause this feeling of, this is happening all over again, which has a delusional quality to it.

Participants affirm that dissociative disorders, multiple personality disorders, and trauma are hard to distinguish from psychosis (RSP1, RSP6, RSP7, RSP8). Indeed, addressing the overlap and distinguishing properly is challenging for clinicians. RSP4 provided an example of a client who had extensive trauma that overlapped with psychosis as well as substance abuse. This example shows the challenges when exploring multiple overlapping trauma events and overlapping trauma and psychotic symptoms.

> RSP4: She had religious trauma, a priest molested her. She grew up in Miami, she had brothers, and she wanted to be the altar boy too. They let her be the altar boy, she was a tom boy. She had a priest do stuff to her. Then she grew up, she became a lifeguard. She became a trauma nurse, she was a firefighter. She actually went up to New York at 9/11 and saw things that she … you know, would mess with your head. And then everything that she saw as a trauma flight nurse. I think that was another traumatic loss is her mom who had died of cancer. She would also act out violently… Then when she would get drunk, it would affect her memory. She would bring and act her trauma like climbing up the outside of the building, and she would hear helicopters. She also found her twin brother, he had killed himself. And she found him. She had a thing about bathtubs and water. Also, when she would get drunk she would end up in a bathtub over in a hallway naked. My professional thought was she's reenacting these traumatic events in her life when she becomes under the influence of alcohol.

This example shows the overlap between the disorders, the role of religious/spiritual culture as a feature in the client's life, and events that contributed to the

development of a mental health and behavioral health disorder. The meaning that the client verbalized and acted out presents as related to trauma as well as psychotic-like and dissociative features. Meaning ascribed to events, symptoms, and features are created and maintained by the person experiencing the phenomena. Meaning may overlap in a cultural experience and in a pathological response to an event. Descriptions of meaning may range from mild to extreme. Participants reported a client found meaning in ascribing little things in daily life as signs of favor from God (RSP6) while another described a client's belief that as a result from trauma they were now demon possessed (RSP8).

The overlap between trauma and psychosis may be further illustrated by RSP8's detailed description of a how a trauma response may appear psychotic. The participant provided a mirror to analyze the clinical criteria for trauma and psychosis by describing alternative ways of interpreting and viewing the phenomena.

> RSP8: Psychosis is just one type of response [to trauma] in terms of all the sort of classic coping and responses, right? And then psychosis kind of can grow out of some of that in terms of the repression or projection onto other people, right? I think you can see how traumatic symptoms, post-traumatic stress disorder PTSD type symptoms, can involve really intrusive stuff and so you could potentially see how that could also … if someone could not accept that or if someone had dissociated that stuff it would feel as though it was coming in from the outside rather than something internally. And so it could be experienced as something totally separate from themselves so, I mean that's kind of how I would think of it,

> that it's so kind of intolerable or whatever defenses they have are not capable of dealing with it. And rather than the classic PTSD symptoms you could get this kind of totally separate sort of dissociative psychosis where the person actually believes those things are coming, you know, from somewhere else. And then there's paranoia right, which is not that different from hypervigilance and that kind of threat awareness kind of response from PTSD.

Underlying Trauma. In addition to trauma overlapping psychosis, participants described their conceptualizations of how *underlying trauma* may also factor in and present as psychosis and psychotic-related features. Participants noted that underlying trauma contributed to the development of personality disorders and other psychotic disorders, including schizophrenia. This was seen through 70% of the participants' responses noting underlying traumatic events and traumatic symptoms pervading into the clients life at significant degrees. Four of 10 participants reported underlying childhood trauma as contributing to developmental, neurochemical, and biological changes in the person (RSP3, RSP4, RSP7, RSP10).

> RSP7: I tend to think that trauma plays a huge role in almost all mental illness like that, coming along the line, developmental trauma, to going all the way back to childhood neglect and the lack of support… fear kicked in early in the brain…[taking] the brain in a different way. When trauma impacts us from an early age, it affects the way the brain is formed. That can lead to different things that are going to be leading to psychosis, leading to schizophrenia, leading to

> anxiety, just from an overall heightened anxiety standpoint that can lead to psychosis as well. I think it's all stemming from trauma at some point.

Participants voiced that exploring adverse childhood events is appropriate clinical practice when tasked to distinguish between trauma, culture, and psychosis.

> RSP10: I'm always going to look at what happened in their childhood. I try to identify the wound. Generally, I find that it has a lot to do with family of origin; particularly a father or a mother who abandoned them or abused them or just didn't show the love that that particular kid needed.

Psychosis with underlying trauma may contain aspects of religious/spiritual symbolism. RSP5 told the story of a client who experienced trauma by way of having to identify the body of a close friend after an industrial accident. The client developed belief's that "anyone around him could be replaced with a vampire at any point." The client was in constant state of distress as the person had a belief that vampires would kill them, him and anyone else around him, in a violent and gory death. The behaviors resulting from these beliefs were that the client moved away from the family and lived in isolated and homeless like settings. When the client was receiving mental health services he and his family disclosed that the person and the friend who was killed had a shared and serious belief that they were vampires themselves. This feature added a layer of complexity of distinguishing diagnostic symptoms. The content related to psychosis and trauma as related through this example shows the challenge to distinguish overlapping religious/spiritual phenomena.

Trauma is important to consider when exploring phenomena that may be religious/spiritual and psychotic. Trauma often overlaps with psychosis and dissociative disorders. Trauma also underlies psychosis and psychotic-related disorders. Participants report it is important to explore natural phenomena such as biology, neurology, and chemistry as well as nurture phenomena such as childhood development and attachment. Another challenge is that trauma and psychosis symptom presentation is similar and that complicates the distinguishing process.

Theme 2: Clinical experience is multifaceted

The second fully actualized theme in this data was that the participant's clinical experience is multifaceted. This theme provides insight to the first research question of how clinicians understand clients' religious/spiritual experiences and beliefs as distinct symptoms from psychotic symptoms needing clinical care/treatment. When distinguishing between phenomena, participants described the central organizing concepts and domain summaries as the argument of it not being an either/or choice, that there is obvious clinical psychosis, and that personal worldview and experience as key features of clinical process.

Not Either/Or. Interviews with the participants revealed similar distinguishing processes in that the *DSM-5* was the primary guideline in distinguishing between religious/spiritual and psychotic phenomena. In varied ways all 10 participants referred to the role of the *DSM* and the importance of following ethical guidelines. Participants acknowledged the *DSM* holds the primary seat in diagnosis in clinical practice and that are guided by the American Psychiatric Association ethical guidelines; however, they

voiced that the diagnostic dichotomy does not neatly fit within all symptoms and diagnoses. Participants agreed that objective measures through discrete forced responses to measure subjective experiences are not ideal. Instead, referring phenomena as *"it's not either/or it is both/and,"* is more desirable. This is a challenge to measure objective reality and subjective reality.

All 10 of the participants expressed, in one way or another, that the dichotomous postulation "is it psychosis or is it religious/spiritual" as a forced choice option is undesirable and limiting. Participants acknowledged that there may be other factors and a combination of factors that may be contributing to the symptom of exploration.

RSP1: The struggle I have when we say is it all this or is it all that…it's always something combination in my mind.

RSP2: You're presenting me an either/or kind of question.

RSP5: I think it has to be more than one situation going on. I have to look at the diagnostic criteria, and see if they've got other diagnoses.

RSP6: It just feels so tricky to know where one thing ends and one begins.

RSP7: So that's physical and scientific things; doesn't mean that they're not also being bothered by something spiritual. It's not either or sometimes.

RSP8: I view it as like there's sort of a range of experience, and it's not like there's a clear line where one of those things is psychosis and one of them isn't.

In addition to wanting to avoid the dichotomous postulation of an either/or choice, participants suggested that the symptoms and phenomena may be considered both/and.

Participants reported that an individual may be experiencing a psychotic phenomenon while simultaneously experiencing religious/spiritual phenomena.

> RSP2: I think that there are people who may have what could be diagnosed as a psychotic break. And then in the construction of making meaning out of it and interpreting it would find that it has an added spiritual dimension. That it can be both [psychotic and spiritual] at the same time.
>
> RSP7: It's one of those fine lines and weird spots where I think there was an element of both. I think she did have trauma happen and some of it may have been not real, but some of it was real.
>
> RSP8: Not like either or. Yeah. I think it's kind of…tough to describe and I think they occur simultaneously like where something could be a spiritual thing but the thought process could be so far gone that it's psychotic or whatever so I don't [think] they're mutually exclusive either.

The challenge of distinguishing both religious/spiritual and psychotic phenomena may be seen within religious/spiritual cultural groups and features that include.

> RSP9: Metaphysical interests like energy healing, energy work over to the occult and the tarot readings and psychics and [Wiccan beliefs/practices]…Shamanism falls under there [too]. Being intuitive or [an] empath, clairaudience, clairsentience, that kind of stuff, just being able to pick up on some of the energy around you or that goes throughout.

These religious/spiritual phenomena may be considered especially challenging when distinguishing cultural phenomena from pathological phenomena. Measuring

phenomena through an objective and subjective lens may be difficult when exploring phenomena that have subjective and objective features, especially as science and faith have been measured on social scales reflective of the time (RSP3).

The central organizing concept of it not being an either/or argument is important to the overarching theme. The central organizing concept provides latitude to explore other symptoms, features, and combinations of mental health and behavioral health factors and thereby providing alternative ways to facilitate meaning making and interpretation of phenomena.

Obvious Clinical Features Another area where all 10 of the participants shared a similar perspective was that there are symptoms that may be considered *obvious clinical features*. Participants provided basic synopses to describe textbook clinical psychosis. Participants reflected on their academic and clinical training experiences whereby psychotic symptoms were relatively straightforward in clinical identification and classification. The participants described their basic conceptualizations of psychosis and the features they commonly associated with psychosis. Three of the participants provided classic and shared examples of a basic conceptualization of psychosis.

> RSP4: With delusion and hallucinations and things like that, you're looking at being able to…with psychosis, you wind up having the agnosia which is the inability to tell the difference between what is real and what's not, or the inability to know that you're sick basically. It's easy to believe something, even if it's not true or real.

RSP7: My basic understanding about psychosis is really that it's a break with reality, that within psychosis, they might be hearing something or seeing something. They might be thinking something and totally believe it, but it's not valid for anyone else and it wouldn't be true for anyone else around them. So it can cause a lot of, obviously, distress for the family and for themselves.

RSP10: My basic understanding is that it exists in the brain. Whatever is occurring in the brain, what's causing it is different, it would be lack of sleep, it could be drugs, [and] it could be hormones. There are various causes of psychosis, but something that's hitting the brain and the person is essentially not themselves.

Participants referred back to textbook examples of psychosis and psychotic phenomena with religious/spiritual content as descriptors of psychosis. High levels of obsession and hyper focus are indicative of psychosis and psychotic-related disorders (RSP9) and often accompany delusional content that can be distressing (RSP5). Textbook psychosis may be seen through obsessive thoughts and speech. “If the person is unable to speak about anything else or it seems like the conversation is constantly veering towards the spirituality or the religious aspect, even when maybe we're not even talking about anything closely related” (RSP9). On the other hand, obsessive intrusive thoughts may make it difficult to carry on a simple conversation.

RSP8: When internal stimuli are so intense that people have disruptions in conversation so you're talking to them and they [are] talking to someone else or they stop and they don't pay attention to you and they're listening to something else

Another obvious clinical feature includes culture overlap. One of the participants reported religious/spiritual phenomena that culturally overlapped by mixing Norse mythology with Christianity and Catholicism (RSP5). In this example, the phenomena did not align with the religious/spiritual cultures and there was a lack of integration and cohesiveness. Participants noted that instances like this are conceptualized as an obvious clinical feature. Disintegration, disconnection, severed and compartmentalized, and rigid are concepts that fit within psychotic phenomena classification with religious/spiritual content.

Auditory hallucinations, hearing voices, are the most common psychotic symptom that is experienced by those that experience psychosis. Participants described textbook examples of auditory hallucinations and negative verbalizations commonly found with psychosis, including the classic symptom of believing they are receiving messages through phones or televisions (RSP4, RSP7, RSP8). Auditory hallucinations that are considered psychotic would be categorized as dark and harmful towards the self and towards others. In addition to the dark and harmful theme, psychotic auditory hallucinations are intrusive and distracting.

> RSP2: Right, well if it's a message, like, "Kill the president." Or, "Go knife the bartender." Or, "The CIA is watching you."
>
> RSP4: I believe that psychosis is more of a command, like hallucination… psychosis is a continuation of this constant chatter. It's constant, 24/7.
>
> RSP5: This is definitely somebody else. This is five other people yelling at me, and telling me I'm garbage. Or, telling me I need to go jump off a bridge.

Participants reported an obvious key feature of serious mental illnesses relating to psychosis and psychotic-related disorders is the deficit of ability to function in day to day life. All 10 participants in the study acknowledged that the degree of functioning is a primary factor when distinguishing religious, spiritual, and psychotic phenomena. The lack of functioning was reported in interpersonal relationships, cognitive deficits, disorganized cognition, and poor emotional regulation skills (RSP1, RSP2, RSP6, RSP8, RSP10). Participants voiced that the symptom of isolation manifests and "they don't want anyone, they don't want to stand out, and they want to blend in" (RSP1) as well as "disconnect from people, disconnect from functioning" (RSP2).

Personal Experience and Worldview. Participants reported *personal experience and worldview* is paramount to the theme clinical experience as multifaceted as the clinician has an important and powerful role within the counseling relationship. "We all have such a [confirmation] bias…seeing what we want to see and hearing what we want to hear" (RSP3). Participants reported their personal experience and worldview as a significant guiding tool in clinical practice in various ways. Nine out of 10 participants reported past and current religious/spiritual beliefs and practices as a part of their personal experience and worldview. 60% of the participants reported engaging and belonging to a Christian faith based group when they were children; 10% were Catholic.

Participants shared engagement with a wide range of main stream religious/spiritual cultures: Catholicism, Mormonism, Christianity, Charismatic Christianity, Protestant/Baptist (RSP1, RSP3, RSP4, RSP5, RSP6, RSP7, RSP8, RSP10). Participants reported engagement with alternative religious/spiritual cultures. Psychic

families with precognitive abilities, psychics, shamanism and indigenous peoples (RSP2, RSP4) as well as Secular Buddhism and Wiccan (RSP5) were reported as past and current beliefs and practices. These participants reported that as they had personal experience with religious/spiritual phenomena they were open and willing to listen and explore other religious/spiritual phenomena. The participants reported that their early experiences with religion/spirituality helped to develop a clinical style of openness and safety.

> RSP8: I actually come from a background of being raised in a very charismatic religious community…the idea that some experiences some people would think are bizarre could be kind of an appropriate like spiritual practice...I grew up speaking in tongues and believing in faith healing.

Participants reported an openness to be willing to listen to phenomena that may be similar to current and past held beliefs as well as being open to listen to completely unknown religious/spiritual beliefs (RSP2, RSP3, RSP4, RSP6, RSP7, RSP8). These participants agreed that it plays an important part in distinguishing between religious/spiritual and psychotic phenomena.

> RSP2: We can go this way. We can go that way. We can look at both of them. And sometimes I'll just do what I'll call put the chess piece on the table. I'll just say, "I'm aware of [this phenomena].
>
> RSP3: So if you come to me with this really scary experience that I'm hearing it and going, oh that's a real cool thing that just happened to you. I certainly don't

want to dismiss your fear, but I might say, gosh, if that had happened to me I might think, dah, dah, dah, what does that sound like to you?

RSP5: If they've got voices and they think that they have healing energy, then I have to look and say, "Okay." I might actually explore something.

RSP6: Because of my experience within my own family, and then a disillusionment of faith … I feel like I'm in this holding place of, I'm not labeling things for myself right now, because that doesn't feel safe for me. I feel like I experience certain things in a spiritual way still, but not within the same constructs as before. When people process their spiritual experiences, I try to just be really careful about how I'm responding to it or interacting with it. In my mind, if it feels real for them, I'm going to work with it in session as if it's real for them, because that is their experience.

RSP7: To be honest with you [there are those] that are quite out there, as some people would say, with their beliefs. I really, I don't think they're psychotic. I think that they are strengthened and blessed and grown by what they're experiencing and whether or not I can experience it is a totally different story.

Participants did not like the either/or dichotomy and verbalized preference for having a balanced view when it comes to exploring religious/spiritual features in light of psychosis and trauma. Obvious clinical features and personal experience and worldview may be seen as two sides of a sword. On one side there is the clinical academic work, skilled training, and evidenced based content and on the other side there are the personal worldview and shared religious/spiritual experiences. The participants reported that a

combination between clinical knowledge and personal experience helped them to develop clinical skill when distinguishing between religious/spiritual and psychotic phenomena.

Theme 3: Similar language is used to describe religious/spiritual and psychotic phenomena

As described in the literature review in Chapter 2, religious/spiritual and psychotic phenomena may be difficult to describe as they are described in similar ways. Similar and distinct religious/spiritual groups may use the same word to describe different phenomena. The third major theme resulting from this study is that similar language is used to describe religious/spiritual and psychotic phenomena. This theme provides insight to the challenges of distinguishing. The theme of similar language used to describe religious/spiritual and psychotic phenomena were reported by 100% of the participants. Three hundred and four codes were created through the data analysis when looking at words and terminology to describe phenomena. Cultural religious/spiritual language and pathological language overlap and similar words, phrases, and concepts are used to describe similar phenomena.

The first central organizing concept and domain summary for this theme, codes were described as religious/spiritual and psychotic *(RSP) language overlaps* and religious/spiritual and psychotic *(RSP) language is similar*. For this code RSP was designated as Religious, Spiritual, and Psychotic. The other central organizing concepts and domain summaries were that the role of *culture* is important when looking at similar language as well as the actual *process and content of clinical conversations*.

In the following examples, participants describe religious/spiritual and psychotic phenomena as similar and depending on the accompanying cognitive, affective, and physical functioning they could be conceptualized as religious/spiritual and psychotic.

RSP Language is Similar. There is considerable overlap and similarities between multiple religious/spiritual culture groups. Similarities may be seen through Native American, Christianity, Hinduism, Islam, and Buddhism (RSP2, RSP4) as well as astrology, metaphysical groups, more fundamental Christian groups (RSP9). "I was struck by the similarities between them. There are so many more similarities between the religions, or the denominations should I say, versus the differences" (RSP4). In these groups the language used to describe religious/spiritual phenomena as well as a psychotic experience are similar. Similarities fall within paranormal, spiritual, and indigenous beliefs and practices. These beliefs and practices may be conceptualized as falling on a spectrum where on one side the phenomena seems mild and helpful and on the other side extreme and stressful.

> RSP8: It has a lot to do with how people interpret…maybe spiritual beliefs they have integrates well with [the phenomena] and so it makes sense for them. I have a client who believes he's been possessed by a demon and that is very distressing, he's upset with that experience. But I have other clients who believe they see ghosts and they're like, that's just a cool thing about me.

One participant reported that Christianity, more than other religious and spiritual groups, contain more psychotic language to describe satan and demons as "big old scary evil stuff that a person can personify and see, hear, [and] touch," that is reinforced by

religious and spiritual culture (RSP5). This is affirmed through participant accounts of clients reporting they are demon possessed, that the devil and demons are tormenting the person, and through religious and spiritual delusions perverting Biblical texts through bizarre delivery of sacred words (RSP3, RSP4, RSP6, RSP7, and RSP10).

While Christianity may contain a high degree of religious/spiritual phenomena that overlap into psychosis, it is also considered normal to have intimate and personal experiences with the central figurehead, Jesus Christ. Participants in the study described Christian experiences with Jesus as Him hearing and engaging in conversations with the person (RSP7, RSP9), as receiving guidance and direction (RSP4, RSP5, RSP7), and simply being present (RSP5, RSP6). Participants reported that these examples are considered normal religious/spiritual phenomena within the Christian culture and within the Christian worldview. From the participants responses one can conclude that the presentation of the person reporting the phenomena will determine how the clinician distinguishes and conceptualizes the phenomena.

The example of energy as language to describe religious/spiritual phenomena was used in the literature review. I discussed how energy may be used across varying religious/spiritual culture groups and have different meanings ascribed to energy. Energy is included as a feature in Christianity, Native American spirituality, Muslim, Catholic Mystics, and Buddhist religious and spiritual groups. These cultural groups differ in the religious/spiritual meaning of their culture's worldview of shared experiences, beliefs, and behaviors.

Participants reported an overlap with the language used to describe energy as a religious/spiritual phenomenon that may also be considered a psychotic phenomenon that may or may not be distressing for the client. Energy was referred to as positive and negative phenomena by no less than six of the 10 participants. Participants described traditional and nontraditional religious/spiritual energy phenomena in both broad and deep positive and negative ways. “Spiritual features can be positive or negative. Positive features where they think that God's talking to them and they're feeling really good about it or negative features where they feel like there's demonic implements” (RSP7).

Positive descriptions of religious/spiritual energy were described as “light, or a realization, or a voice that's kind and supportive…some people refer to it as conscious, or spirit, or Holy Spirit, or Jesus. Energy” (RSP4). Auras and bright lights described personal energy fields (RSP1) and the acknowledgement that “they feel energy,” and that “they feel that they're in touch with a larger energy” (RSP5) were reported as positive features. Participants also reported client’s religious/spiritual experiences and beliefs related to energy included visiting with angels, numerology, having out of body experiences (RSP9); having the third eye tell the person that the chakras are misaligned (RSP8); being able to travel through time and visit people from the past (RSP5); Reiki and Yoga (RSP4), Shamanism (RSP2), and having precognitive abilities, finding lost things, knowing peoples secrets, communicating with spirit world, and having prophetic dreams (RSP2).

Similar language is used to describe potentially negative religious/spiritual phenomena. In Indigenous cultures describing “a spiritual intrusion where an ancestor

spirit or unquiet spirits, someone who's dead but hasn't crossed over, or even somebody who's living but has some problems or ill wishes" (RSP2), and "ghosts and the ancestors who sent her visions and dreams" (RSP3) are normal within that culture context. Outside of that culture context, however, the phenomena may be considered psychotic.

Another negative energy description was that "their energy field is small and sharded and fragmented…haunted or cursed…physiological sensation of being burdened and heavy…[Breathing] shallowly" (RSP2). Another participant described an experience of feeling the phenomena of energy while in session with a client (RSP6). Energy was described as tangible and "it was like there was this energy and this prickliness." Initially the energy took on an asexual form; however, the phenomena then transformed into a masculine form of energy. "I don't really know what to make of it, but it did feel like there was more of a masculine energy that was showing up" (RSP 6).

In similar language, it is extremely important to explore the role of culture when distinguishing between religious/spiritual and psychotic phenomena. Some cultures are more accepting of supernatural phenomena and will attribute negative features of mental health on religious/spiritual features. RSP10 reported that it is common for Hispanic persons and Indigenous persons to ascribe to the belief system of demon possession. On the other hand, RSP4 reported that a young white male experiencing command hallucinations describing the experience as internal battle with satan as spiritual warfare was noted to be psychotic.

In the literature review I refer to two case studies (Bhargav, Jagannathan, Raghuram, Srinivasan, and Gangadhar, 2015; Valanciute & Thampy, 2011) that guided

me throughout the study when listening to participant experiences. I named them Spiritually Advanced or Psychotic and Spiritual Awakening or Psychotic Break. While I interviewed participants and faithfully reported their meaning and interpretation of events, I was also exploring the content of the examples given by the participants. I was cognitively running the content and presentation of the phenomena through these case examples to help refine understanding on how clinicians distinguish between religious/spiritual and psychotic phenomena. The two case studies helped me to explore how overlap in religious/spiritual cultures may manifest and how the religious/spiritual language can be right but something else is wrong.

Six participants used similar religious/spiritual terms to describe a spiritually advanced person or person who experienced a spiritual awakening that could be considered psychotic. RSP5 and RSP6 both agreed that a spiritual awakening and enlightenment and a religious/spiritual crisis would not be considered psychotic; however, the language to describe those religious/spiritual events overlaps with psychotic language. RSP10 added a distinguishing feature that a genuine spiritual awakening would have long lasting positive effects in the person's life, not just a "shallow flash in the pan" experience.

RSP7 described a similar case to Spiritually Advanced or Psychotic through a story of a client reporting visions and angelic activity with Biblical linguistic accuracy; however, the presentation was off, bizarre, and did not present as congruent to the meaning of the texts. This participant also shared another story where a client would stiffen and speak using Old English language. These two examples affirm how the

language and words are accurate, but the delivery and presentation of the words are incongruent. In another example, a person was mixing religious and cultural features of Norse and Christianity (RSP5). Spiritual Awakening or Psychotic Break was described by RSP3 as the zeal and passion of a spiritual awakening may mirror psychotic obsession and hyperfocus. This suggests that a key feature when distinguishing between Spiritual Awakenings, Spiritually Advanced persons, and psychosis, is the lack of congruence and cohesiveness between religious/spiritual language and presentation and delivery of the content of the language.

Three participants also noted that becoming a spiritually advanced person is an intentional endeavor whereby the spiritually advanced person will seek out knowledge and skill building to accompany the religious and spiritual phenomena (RSP2, RSP4, RSP9). Of important note, while participants reported that intentionality is key in having religious/spiritual experiences, one participant noted that even with intentionality, religious/spiritual experiences found with spiritually advanced and spiritually awakened persons may not be apprehended, “I wanted to have that kind of spiritual experience but I kind of couldn't” (RSP8).

The question stated at the start of Chapter 2, “Could a delusion be a description of an authentic spiritual experience?” (Rapsomatioti, 2014, p. 204) guided the intention of the study. The results show that some of the examples given by the participants may be considered as an affirmative yes. Participants would describe and explain phenomena that could be considered psychotic and upon cross examination acknowledged that the phenomena may also be a genuine religious/spiritual experience.

By far*, similar language to describe* was the largest coded theme in the study. This is a logical conclusion as the purpose of the study was to gain insight to how clinicians distinguish differences as the phenomena of religious/spiritual and psychosis overlap. Similar language is used to describe a genuine faith experience as well as a pathological experience. Participants reported similarities between religious/spiritual groups as well as agreement on what differentiates positive and negative features.

Cultural Considerations. The role of culture was stressed in the literature review as an important feature when exploring religious/spiritual and psychotic features. I took a multicultural approach to this study as religious/spiritual features have distinct and overlapping facets within many cultural groups and practices. I noted that a multicultural framework would be useful as a Western framework may not provide a satisfactory lens to explore cultural phenomena. This was affirmed throughout the study as nine out of 10 participants acknowledged the importance of culture when exploring the cultural, religious/spiritual phenomena in light of pathological, psychotic features. Culture was referred to and coded 80 times during data collection in the interviews as well as making meaning, which was referred to and coded 87 times. The central organizing concept and domain summaries were *culture consideration* and *culture.*

Culturally Competent Clinicians. Consideration of culture is necessary to be a *culturally competent clinician.* Culture may be important to the client, it may have similar features to other cultures and it may differ from other cultures. Culture may be conceptualized as fluid, rather than static and rigid. After discussing the *DSM's* stance on culture bound as a phenomena limited to demographics and geographical location the

participant reported, “[that is] boring…we're lucky to have a whole smorgasbord or beliefs and practices available and people can pick and choose was suits them” (RSP2).

Participants noted that meaning differs across cultures (RSP2) and acknowledged that beliefs and exposure to life experience influences personal culture (RSP1). RSP6 aptly stated, “What we consider as normal or acceptable to talk about or what we ascribe meaning to shifts so much across cultures.” Half of the participants reported that the *DSM* is not their go tool for culture competence and that it is lacking cultural instruction when distinguishing cultural features (RSP3, RSP7, RSP8, RSP9). “Well, I do think that there probably needs to be more emphasis on cultural aspects” (RSP9).

Cultural competence aims for holistic care of the individual by acknowledging key aspects that are important to the individual. This may include knowing specific religious/spiritual cultural phenomena (RSP10). 40% of the participants affirm culture competence and stressed the importance of having cultural knowledge that provides room for appropriate clinical meaning and interpretation.

> RSP4: I believe that clinicians need to be culturally competent; I think clinicians should take it upon their selves to do a lot more culturally competent training. I'm not just talking about LGBTQ or white and black, or other ethnicities. I'm talking about spirituality, different states, [and] different countries. Different indigenous cultures, and at least have some type of knowledge about their religious practices, about what healing looks like to them.

Norms within Culture and Culture in Context. Nine of the 10 participants noted that acknowledging religious/spiritual *norms within culture* as well as looking at

the cultural norms within their contexts are a key way of distinguishing phenomena. This process becomes more challenging as social fabric changes and cultures become more fluid. Participants acknowledged that viewing certain religious/spiritual phenomena through a Western culture lens may label the phenomena as psychotic and not socially accepted as normative within their cultural context (RSP3). It is important to be able to make distinctions between Western and Eastern countries (RSP1, RSP4, RSP5, RSP7). Two examples support the affirmation. Some cultures believe in and engage in the practice of speaking with the dead (RSP3, RSP6, RSP7). In one example a participant reported a client sharing how their dead mother communicated with her tangibly and audibly (RSP6). The participant noted that it was normal for the culture. In another example, other countries that practice ceremonial witchcraft including having the dead speaking through the person (RSP7) is also noted as normal within culture. “There's just a context for it that makes sense in that particular cultural context where outside of that it wouldn't necessarily make sense,” (RSP8).

Clinical Conversations. The code of *clinical conversations* directly answered the RQ2: How do clinicians engage in conversation and explore their clients’ religious/spiritual experiences and beliefs and psychotic symptoms needing clinical care/treatment? A main part of this study was to explore the process and content of exactly what is said and how is it being said in clinical sessions when distinguishing between religious/spiritual and psychotic phenomena. I asked participants if they used certain scripts or prompts to initiate positive clinical conversations as well as how they

verbalized distinguishing inquiries that were clinically fruitful. Participants affirmed that it is a challenging process to explore religious/spiritual and psychotic phenomena.

Interestingly, fear of talking about religious/spiritual phenomena that may be interpreted as psychotic phenomena, was reported by eight participants as something that both clients and clinicians experience. Six participants reported that clients feared they would be labeled crazy or be diagnosed with psychosis as well as their experiences would be dismissed as unimportant. Participants reported a fear of not being believed (RSP5, RSP9). Having discussions about "crazy" content was considered intimidating (RSP2, RSP6). Participants also reported that clients who felt their experiences would be dismissed had difficulties trusting the clinician (RSP5, RSP7, RSP10).

Participants voiced a fear of talking to other clinicians about religious/spiritual knowledge and experiences. One reason for this fear, the participant reported, is that it may "discount my credibility as a clinician" (RSP3). Another participant noted that as soon as certain religious/spiritual content was known among other clinicians that they "immediately started kind of talking down to me" (RSP10). While there may be stigma relating to religious/spiritual experiences, beliefs, and behaviors, participants who reported having religious/spiritual experiences believed that the experiences made an impact in their ability to address religious/spiritual phenomena in clinical practice (RSP2, RSP3, RSP4, RSP6).

RSP3 told a story of a client who wanted to use their spirituality as an aid to healing. The client was admitted to hospital and wanted to place healing crystals under the bed in accordance to the religious/spiritual culture. RSP3 overheard other clinicians

make fun of the client and the participant sought supervisory guidance. This example illustrates the challenge of clients and clinicians to openly discuss religious/spiritual cultural beliefs and practices.

In addition to fear of disclosure by both clients and clinicians, participants affirmed the challenge of just starting and engaging in conversations that contain religious/spiritual and psychotic content. Conversations were referred to as "having to walk the tight rope" (RSP1) and as "a very fine line" (RSP7).

Process and content of clinical conversations. Clinical conversations are settings in which clinicians discuss phenomena with the client to come to an accurate conceptualization of the mental health and behavioral health problem. In this study, there are 101 references and codes found in all ten participant interviews relating to the *content and process* of clinical conversations when exploring religious/spiritual and psychotic phenomena. The central organizing concept and domain summary was *clinical conversations* and *process and content*. Participants discussed their process of clinical conversations and how they go about talking about potentially sensitive religious/spiritual and psychotic phenomena.

Initially, the informed consent, disclosure, or intake form provides an avenue for discussion. Participants noted standard questions such as "Do you have a spiritual belief and do you hold on to any particular religion?" (RSP3); and "Do you have any spiritual or cultural beliefs that you would like to kind of make part of your recovery?" (RSP4).

After the initial assessment is completed and the process of therapy begins, the participants reported similar gentle approaches when exploring religious/spiritual and

psychotic phenomena (RSP1, RSP2, RSP9). Approaches were described as "open and with curiosity" (RSP1); "slow and gradual," (RSP2); "flexible with clients" (RSP4); "fair and straightforward," (RSP8); and with "a curious perspective" (RSP7). Contrary to a gentle approach, participants reported and agreed that outright confrontation is not a successful strategy and may evoke mental health problems rather than alleviate mental health problems (RSP5, RSP8).

When engaging in clinical conversations, participants reported the importance of assessing the client's capacity of insight when exploring cultural and pathological phenomena. "Is the person able to even understand what's going on? Do they have any insight or perception?" (RSP1); are they "capable of exploring it from different angles and different perspectives and coming to a more moderate conclusion?" (RSP7). In addition to exploring levels of insight related in order to have successful clinical sessions, participants noted that the role of the person as the expert (RSP5) also comes into play and that the clinician is to facilitate, not dictate, the meaning and interpretation.

> RSP4: You are not the expert in this person's life. Even though you have all of these pieces of paper that say you're really smart, and that you paid a lot of money for, that person is the expert; because they live their own life every single day. And really turn up the active listening skills, and not have your own education or training interrupt what they're trying to tell you; because that's how you fit the puzzle pieces together for them. You're there to guide, and navigate. And help them.

“We are meaning making creatures. We're looking for other ways of being, other ways of thinking, and other ways of identifying self” (RSP2). Through the use of gentle and slow approaches questions are asked in a “noninterpretative” way (RSP5). Asking noninterpretative and noninferring questions allows the client to describe their experience, belief, and behaviors around the language they are choosing to use to convey meaning. Participants affirmed that there are differences in meaning and that clinicians would do well to not discount seemingly random content.

> RSP8: People explain or attribute meaning to these different experiences. What meaning they give it and I think a lot of things that we call psychosis like do have a lot of meaning for that person but it's not just random content. It has meaning based their experiences. It has to do with like the way they are interpreting things and that can be meaningful.

In addition to participants reported flexibility in their approaches in using cognitive, affective, and sensory questions, theological questions may be asked as well (RSP10).

> RSP5: If they've got voices and they think that they have healing energy, then I have to look and say, "Okay." I might actually explore something. "Tell me what this healing energy does? How does it work?"
>
> RSP10: It depends on the theology of what they're saying. So you have to approach it with, "Okay, tell me what God has said to you." Or, "Tell me what the angel said to you."

Participants reported using similar questions and conversational prompts to explore the content of religious/spiritual and psychotic phenomena when asking clients to describe their experiences. When engaging in conversations participants noted that a slow and steady pace with open and straightforward discussions are the most fruitful. The level of insight and ability to have discussions about the phenomena provides insight to the interpretation and meaning ascribed to the phenomena by the client.

Addressing the Research Questions

The purpose of this study was to explore clinician's perspectives when distinguishing between religious/spiritual and psychotic phenomena. For this study, all of the participants who agreed to participate in the study had personally experienced the distinguishing process firsthand. I had two foundational research questions that addressed understanding the phenomena and skill to address the phenomena. The first research question was (a) how do clinicians describe their understanding of clients' religious/spiritual experiences and beliefs as distinct symptoms from psychotic symptoms needing clinical care/treatment? And (b) how do clinicians engage in conversation and explore their clients' religious/spiritual experiences and beliefs and psychotic symptoms needing clinical care/treatment? The first two themes that emerged in the results, trauma is an important consideration when exploring religious/spiritual and psychotic phenomena and clinical experience is multifaceted, responded to the first research question. The third theme that emerged, similar language is used to describe religious/spiritual and psychotic phenomena, responded to the second research question.

The first research question was strongly met with the theme of the role of trauma as an important feature to explore. Trauma overlaps with other mental health disorders and symptoms. The psychotic spectrum overlaps with trauma and stressor related disorders including dissociative identity disorder and multiple personality disorder. Trauma was also discussed as underlying psychosis. Trauma was often referred to as an event that occurred in childhood that did not receive treatment and eventually the traumatized person developed psychotic-like symptoms in response to attempting to cope with the trauma.

The second theme that was created, clinical experience is multifaceted, relates to the first research questions that sought insight on clinicians understanding of the phenomena of psychosis and religious/spiritual beliefs. Participants voiced clinical academia and experience and personal knowledge and experiences play a significant role in their clinical practice. In this theme the either/or argument was met with distain and participants suggested a better conceptualization may be both/and. The affirmation that there may be psychotic symptoms needing treatment; however, there may also be religious/spiritual phenomena and other mental health symptoms occurring at the same time.

The either/or dichotomy was accompanied with participants reporting that there is obvious clinical presentation of psychosis. Other features such as personal functioning, social functioning, and interpersonal functioning were discussed in degrees of health and wellness. Textbook examples were given for conceptualization of delusion and hallucinations. Delusions were reported as rigid and inflexible as obvious phenomena

when clients report they are a religious and political figure. Obvious hallucinations included nonreligious and nonspiritual phenomena. When challenged to distinguish delusions and hallucinations participants reported a straightforward approach through objective and subjective judgment. Objective judgment was used for textbook psychosis examples. Participants noted that when the religious/spiritual phenomena cross over into subjective judgment it is harder to distinguish. Through clinical experience is multifaceted the clinician uses the tools of clinical psychology practice. Clinicians do not like dichotomous choices and prefer the latitude to explore phenomena on multiple levels in order to deliver the best mental health services.

Personal experiences often included knowledge and engagement in various organized religious groups and structured and unstructured spiritual groups. Through previous and current engagement with religious/spiritual experiences, beliefs, and behaviors, participants reported they operate with openness to dialogue with clients reporting religious/spiritual phenomena. Personal experiences included what the participant experienced firsthand and hearing secondhand information from others.

The second research question seeking insight on how clinicians go about engaging in conversations that contain religious/spiritual and psychotic content was discussed in lively and layered ways. The theme of similar language to describe encompassed this aspect as the language overlap is significant. Participants shared explicit religious/spiritual phenomena that may be considered cultural as well as pathological. While describing religious/spiritual and psychotic beliefs, behaviors, and

experiences, participants voiced the challenge of distinguishing and provided examples of starting clinical scripts to explore the phenomena.

Religion/spirituality are features of culture and are noted as valued and important to the clinician and the client. Participants reported that exploring religious/spiritual features within the clients' culture is paramount when exploring psychotic phenomena. Culture may be difficult to define as it is developed through personal meaning and choice.

Process and content were another way that participants shared their distinguishing process within clinical conversations. Fear of stigma was discussed as a potential barrier for clients to disclose experiencing religious/spiritual phenomena. Participants also reported that they fear stigma from other clinicians. Participants report they start with a slow and steady approach to ease into potentially challenging conversations with a posture of openness and curiousness. Using gentle prompts asking about how religious/spiritual features are conceptualized and how they manifest are ways of exploring the client's meaning. The participants reported that straightforward questions are the best when distinguishing between religious/spiritual and psychotic phenomena.

Summary

This chapter summarized the results of a generic qualitative study using thematic analysis to explore clinicians' perspectives when distinguishing between religious/spiritual and psychotic phenomena. All participants were interviewed with two foundational research questions: How do clinicians describe their understanding of clients' religious/spiritual experiences and beliefs as distinct symptoms from psychotic

symptoms needing clinical care/treatment? And how do clinicians engage in conversation and explore their clients' religious/spiritual experiences and beliefs and psychotic symptoms needing clinical care/treatment? The semistructured interview and open ended questions facilitated unique and deep discussions related to the distinguishing process with the participants. From the participant responses I provided statements that were helpful in the distinguishing process.

Chapter 5 will (a) detail the conclusions from the data analysis and (b) list the implications for social change and recommendations for further research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Distinguishing between religious/spiritual and psychotic phenomena may be a challenging task for clinicians. Religious/spiritual features may be included in a psychotic disorder, present independently of a psychotic disorder, and at times, present simultaneously with a psychotic disorder. The objective in this study was to explore the clinical process that clinicians undergo when distinguishing between religious/spiritual and psychotic phenomena. I used a thematic analysis approach in order to understand clinicians' distinguishing process. Using a semistructured interview, I addressed how clinicians understand their clients' experiences with religious/spiritual and psychotic phenomena, as well as how clinicians and clients were engaging in conversation regarding the religious/spiritual and psychotic phenomena.

Three themes were created from the data. The first theme was that trauma is important to consider when exploring religious/spiritual and psychotic phenomena. The second theme was that clinical experience is multifaceted. The third theme was that similar language is used to describe religious/spiritual and psychotic phenomena.

In Chapter 5, I provide an overview of this study, including a recapitulation of the conceptual framework, the interpretation of the findings, the limitations of the study, and recommendations. I describe the potential for future research and how this study may create positive social change. I obtained these results by interviewing 10 mental health professionals in the United States. Participants were asked to elaborate on the two main research questions: (a) how do clinicians describe their understanding of clients'

religious/spiritual experiences and beliefs as distinct symptoms from psychotic symptoms needing clinical care/treatment? (b) How do clinicians engage in conversation and explore their clients' religious/spiritual experiences and beliefs and psychotic symptoms needing clinical care/treatment? At the end of the interview, each participant was invited to contribute any other thoughts, questions, and opinions she or he might have. The participants' responses contributed to a comprehensive description of their clinical processes.

Conceptual Framework

Before discussing the themes that were created in this study, it is important to review the conceptual framework I used. The themes were analyzed using multicultural, humanistic, and transpersonal frameworks to explore (a) how clinicians engage in the distinguishing process, (b) how they understand and interpret their meaning of the phenomena, and (c) the client's meaning of the phenomena. In Chapter 2, I described multiculturalism and transpersonal psychology as frameworks to assist in explaining the study. I used these frameworks as described below.

Through a multicultural framework I was able to use a broad lens to explore the meaning that clinicians ascribed to religious/spiritual and psychotic symptoms they encountered in clinical practice. I paid attention to how the clinician categorized the symptoms being examined order to gain insight to their distinguishing process when distinguishing between religious/spiritual and psychotic phenomena. The multicultural framework was helpful because it reminded that there is no "one size fits all" culture and that cultures differ in beliefs and behaviors. A multicultural framework was also useful

for exploring the importance of the client's culture while distinguishing between cultural phenomena, religion/spirituality and pathological phenomena, psychosis.

Transpersonal psychology was useful as it openly leans toward exploring alternative religious/spiritual phenomena. Transpersonal psychology has phenomena fluidity that assisted me to explore the overlap between religious/spiritual and psychotic features. The combination of multicultural and transpersonal lenses was beneficial due to the wide acknowledgement of cultural phenomena.

Interpretation of Findings

Psychosis is one of the most researched phenomena in mental health. One of its challenges is that symptoms related to psychosis overlap with other mental health disorders and cultural features, which may include religion/spirituality. Exploring the content, context, and behavior related to religious/spiritual features within psychotic disorders is worthwhile. As there is scant research on distinguishing between religious, spiritual, and psychotic phenomena (Benning, Harris, Rominger, 2019; Goretzki, Thalbourne & Storm, 2013; Hustof, Hestad, Lien, Moller & Danbolt, 2013; Koenig, 2009; Phillips, Lukoff & Stone, 2009), I set out to answer the actual "how to" process that clinicians use to distinguish between the phenomena.

Three themes emerged from the data in the study. First, trauma is an important consideration when exploring religious/spiritual and psychotic phenomena. This theme was supported with central organizing concepts of trauma overlapping and trauma underling psychosis. The second theme created was that clinical experience is multifaceted. This theme was supported through three central organizing concepts: a

rejection of a dichotomous choice, that in clinical experience there is the element of a textbook understanding of psychosis, and that the clinician's personal experience and worldview do play a part in the distinguishing process. The third and final fully developed theme was that similar language is used to describe religious/spiritual and psychotic phenomena. Central organizing concepts highlighted three main issues: the notion that religious/spiritual and psychotic language overlaps and that overlap creates conflict, that cultural considerations must be made when distinguishing religious/spiritual and psychosis, and that it is relevant to engage in sensitive clinical conversations when exploring the phenomena.

Theme 1: Trauma is an important consideration when exploring religious/spiritual and psychotic phenomena

A finding that is unique to this study is the open and eager discussions related to the role of trauma when exploring religious/spiritual and psychotic phenomena. Given the fact that participants who responded to the recruitment flyer were called on to discuss the distinguishing differences between religion/spirituality and psychosis, the attention to trauma increases its significance. In reviewing the literature on this topic, trauma was not addressed in the literature review. I had a narrow focus to explore the overlap between religious/spiritual and psychotic phenomena and did not include trauma as one of the features of discussion. While I am aware that trauma and psychosis overlap, I was taken by surprise at the participants' eager responses to include the trauma topic and the focused attention discussing the role of trauma when looking at supernatural and psychotic phenomena. A simple search of trauma as overlapping other mental health

disorders and symptoms and trauma underlying psychosis clearly showed as a topic of interest in the existing literature and research matrix.

Trauma, like psychosis, is described on a spectrum. Trauma and psychosis spectrums share similar characteristics, and both retain positive and negative features including disorganization, suspiciousness and hypervigilance, and negative and intrusive thoughts (Gibson, Alloy, & Ellman, 2016; Renard, et al 2017). There are many overlapping symptoms between the schizophrenia spectrum and the trauma spectrum. Dissociative states as positive and negative features are commonly found within trauma and psychotic diagnoses (Renard, et al, 2017). The overlapping symptoms may be viewed through the lenses of multifinality and equifinality. Multifinality may be seen as a concept of multiple outcomes originating from a single source, and equifinality as a concept in multiple sources leading to a single outcome (Gibson, Alloy, & Ellman, 2016). These lenses to explore the overlap fits well in the current study as many of the participants were quick to note that trauma often underlies psychosis as it is considered a primary event in the development of psychosis as well as trauma and psychosis overlapping with other mental health problems and disorders. The participants in the study provided clinical conceptualizations where multifinality may be seen through trauma as the underlying root with subsequent multiple mental health symptoms and problems. Equifinality may be seen as the combination of many mental health problems leading to psychosis. To address multifinality and equifinality, clinicians are attentive to exploring childhood experiences, exploring childhood trauma if appropriate, as well as human growth and development and the attachment processes.

Current literature affirms significant comorbidity between trauma and stressor related disorders and psychosis and psychotic-related disorders as childhood trauma can be indicative of developing a psychotic disorder (DeTore, Gottlieb & Mueser, 2019; Veling, Counotte, Pot-Kolder, van Os, & Vandergaag, 2016) In DeTore, Gottlieb and Mueser's 2019 study exploring the role of posttraumatic stress disorder PTSD in first episode psychosis, no significant differences were found with age and gender when exposure and experience to trauma and traumatic events occurred, save noting that women were more likely to experience childhood sexual abuse than men, also affirmed in Veling et al.'s 2016 study. These authors also stressed assessing the role of negative cognition and low self-statements and social stigma and social isolation as features of both trauma and psychosis. These results were affirmed with the current studies participants' attention to explore the role of trauma when exploring phenomena with religious/spiritual and psychotic content.

Theme 2: Clinical experience is multifaceted

Clinical practice may be conceptualized as a combination of foundational psychology theory, current psychology theory, academia groups and discussion, and professional and personal experience. These aspects blend with and stand-alone from one another. In the theme of clinical experience is multifaceted participants agreed that the either/or position is limiting that textbook clinical psychosis is a simple baseline of sorts, and that personal experience and worldview are important and used as a guide in clinical practice.

Interestingly, textbook clinical psychosis and the either/or argument appear to fit together and contradict itself simultaneously. This may be seen through Ishibashi's (2005) work drawing attention to the clinical training to either mark the presence or absence of a symptom to meet diagnostic criteria, yet noting that symptoms do not always conform to a mental health diagnosis. Participants noted this when religious/spiritual and psychotic phenomena present and overlap with multiple symptoms and diagnoses.

When addressing religious/spiritual phenomena within the clinical encounter, clinicians are challenged to be aware of their own processes while simultaneously addressing the clients' processes (Jacobs, 2010). For the clinician this means that while they are exploring content and meaning presented by the client they are using their own clinical experience and personal experience to understand what the client is telling them. It is a challenge to distinguish pathological clinical symptoms and the meaning and beliefs the client has about those symptoms in the clinical encounter (Hustof, Hestad, Lien, Moller, & Danbolt, 2013).

A unique aspect of this study was the deep attention to the personal worldview including past and present religious/spiritual experiences that contribute to clinical practice. Participants who personally experienced, or personally knew of others' experiences, reported being very open minded and willing to engage in conversations that may contain religious/spiritual cultural features as well as pathological psychotic features. Personal engagement in religious/spiritual experiences, beliefs, and behaviors assist the clinician to explore clinically relevant content as well as possessing more

favorable approaches to integrating mental health treatment with clinically appropriate religious/spiritual interventions (Rosmarin, Green, Pirutinsky, & McKay, 2014).

The participants exemplified how etic and emic perspectives are useful in clinical practice. Using etic and emic perspectives may be considered a strength as it gives latitude to explore phenomena with a multicultural lens. Through religious and cultural engagement in groups and practices an etic perspective may be useful to check for norms within the culture as well as identifying phenomena that does not align to the religious/spiritual culture. Viewing the phenomena outside of the culture through an emic perspective is also beneficial as the societal norms and social fabric may be explored.

In addition, etic and emic perspectives are a part of positionality and may be considered as objective and subjective (Bourke, 2014). This aspect is very helpful and aligns with the eschewing of an either/or argument and adopting a both/and perspective. Etic and emic positionality encourages objective and subjective judgment through clinician acknowledgement as an insider of the culture and an outsider of the culture. Etic and emic perspectives are also important to consider when exploring the psychological and existential framework of the client as it may determine beliefs, values, and morals (Whitley, 2012). Understanding the diverse perspectives of etic and emic positions may also assist the clinician to understand the "inner and outer worlds" of the client (Jacobs, 2010, p. 100).

Clinicians are tasked with mental multitasking during clinical encounters. Clinicians explore mind, body, and sometimes spiritual features that require multiple perspectives in order to provide client centered and clinically appropriate treatment.

Clinical experience is developed through personal experience from seeing multiple clients. Clinical judgment is composed of clinical training and personal views

Theme 3: Similar language is used to describe religious/spiritual and psychotic phenomena

The third and final theme in this study is that similar language is used to describe religious/spiritual and psychotic phenomena. One of the participants referred to the quote, "The psychotic drowns in the same waters in which the mystic swims with delight" by Joseph Campbell affirming the difficulty to discern the differences between the phenomena. Psychosis and mysticism are closely related. As noted in Chapter 2, mysticism is conceptualized as a broad spectrum of experiential phenomena as well as psychosis. Religious/spiritual spectrums and psychotic spectrums were abundantly discussed in this unique study. Similar language to describe encompassed exploring the linguistic paths used when describing religious/spiritual and psychotic phenomena including attention to culture. In this theme the language used in the clinical encounter as well as how the language is used was addressed.

Similar language is used to describe phenomena found in multiple religious/spiritual cultures. Stories are similar with similar adjustments across Native American, Christian, and nontraditional spiritual groups. The adjustments reflect the culture that is experiencing the religious/spiritual phenomena. The way that the people process the phenomena and ascribe meaning to it dictates the language to describe the phenomena.

An interesting finding in this study were that the participants shared a similar process in choosing the language they use to explore religious/spiritual and psychotic phenomena and the underlying meaning explored in the clinical processes of distinguishing between phenomena with their clients through the use of transpersonal psychology. Transpersonal language includes spiritual and religious language that is used in broad and diverse ways (Grof & Grof, 1989). As spirituality is considered subjective with diffuse meanings (Huguelet & Koenig, 2009) and clients may use mystical terms that are not easily defined (Lukoff & Lu, 1988) language fluidity may be considered beneficial. This is seen as valuable through Jacobs' (2010) findings on the need to have insight on the "fluidity of definitions" (p. 115). It was encouraging to see the participants in this study were aligned in their insight on the flexibility of language and their ability to use flexible language. The ability to address clients' religious/spiritual cultural beliefs assisted the participants in avoiding potential cultural encapsulation (Heppner, Wang, Heppner & Wing, 2007). Potentially valuable information may be gleaned from the transpersonal verbiage and language that clinicians use in their distinguishing process.

Through the participant responses it became evident there is openness to discuss nontraditional paths of religious/spiritual cultural beliefs and practices. Participants involved in this study seemed to hold more of a multicultural perspective allowing for multiple types of phenomena with multiple explanations of meaning.

Language has influence within the clinical context (Ishibashi, 2005). This unique study sought out how the language of religious/spiritual and psychotic phenomena are interpreted and given meaning. This is especially important when considering the role of

culture in a mental health context. Culture may be seen as a vehicle to transmit the meaning ascribed to phenomena in order to identify and describe experiences. Paying attention to the cultural language of the client and the meaning placed upon the content is paramount.

Culture shapes the presentation of psychosis (Whaley & Hall, 2009). In their 2009 study exploring cultural themes related to race/ethnicity and religious phenomena in African American clients they note differences between confluent paranoia, cultural paranoia, and clinical paranoia. This illustrates the overlap between culture and pathology as well as showing similar language with different meanings. Understanding the differences between cultural phenomena, including beliefs and attitudes relating to religious and spiritual phenomena, and psychotic phenomena in need of clinical treatment is invaluable (Mirza, Birtel, Pyle & Morrison, 2019).

Clients may be hesitant to share religious and spiritual phenomena with the clinician for fear of judging phenomena too quickly and being labeled crazy (Benning, Harris, & Rominger, 2019; Roxburgh, & Evenden, 2016). Ishibashi (2005) notes this as a barrier if the diagnosis is so stressed that the clients meaning is dismissed as unreliable. The participants in this study affirmed that they are aware of this fear and have experienced this firsthand.

As noted in Chapter 2 that there is a need for common language when speaking to other clinicians as cultural religious/spiritual language is similar to other cultures; however, having conversations is difficult when clinicians are not having them for fear of stigma, disrespect, or dismissal. This may mirror a skill deficit that may be seen through a

"reluctance to inquire" about religious and spiritual features (Rosmarin, Green, Pirutinsky, & McKay, 2014, p. 194). Whitley (2012) posits that a priority in mental health ought to be a safe place for "cultural issues and identities" including religious and spiritual discussions in a respectful manner (p. 251).

Acknowledging the call to be culturally competent mental health professionals, integrative modalities including religious and spiritual cultural aspects are now being provided within graduate level courses (Raheim, & Lu, 2014). Interventions and modalities that were once thought of as alternative are beginning to make their way into mainstream clinical practice.

Limitations of the Study

At the outset of this study, I stated that a potential limitation may be due to the small and unique sample available, including the professional novice levels of the participants. Participants' professional experience as clinicians ranged from less than one year in clinical practice to 10 years in clinical practice. The voices of more seasoned clinicians were missing in this study. Clinical positions included one in an incarceration setting, one in a chemical dependency setting, three in community mental health settings, and five in private practice settings. Recruiting in specific mental health sites where more seasoned clinicians practice, including specifically recruiting for licensed psychologists and licensed psychiatrists, may have provided a more extensive range of clinical experience. Results of this study may not be transferable beyond the specific population of licensed mental health professionals in the United States who participated in the study.

Another noted limitation was that the participants' results may not have accurately reflected the opinions of all members of the population of research. All participants who responded to the research invitation reported some level of past and current experience with religious/spiritual culture. None of the participants identified with atheism and agnosticism. Notably, one participant identified as a Christian working in a non-profit Christian counseling agency, another as a Catholic working in community mental health agency, and another as a Shaman working in private practice; however, none of these participants provided solely religious/spiritual mental health counseling. As the participants had personal experience with religious/spiritual cultures it is important to note that it may play a role in how they perceive religious/spiritual phenomena and psychotic phenomena.

Finally, I did my best in addressing my own bias by following different trustworthiness guidelines through journaling and memos. I also attempted to remain aware of my positionality as a religious/spiritual individual throughout the study and set aside my personal views.

Recommendations

Additional research is warranted to explore the exposure to trauma, the presence of trauma, and the role of trauma with persons who present with psychotic features in need of clinical care (DeTore, Gottlieb & Mueser, 2019; Gibson, Alloy, & Ellman, 2016; Veling, Counotte, Pot-Kolder, van Os, & Vandergaag, 2016;). Unlike distinct diagnostic systems which typically present a clear course of disease, disorder and illness noting where overlaps in symptoms may or may not occur, one of the challenges of

differentiating between the psychotic spectrum and the trauma spectrum are that there are many overlapping symptoms between the two spectrums (Renard, et al, 2017). Differential diagnoses may be complicated as schizophrenia and dissociation include the same symptoms. Future research analyzing the unique and overlapping symptoms of schizophrenia and dissociation in diagnostic networks and exploring the specific similarities and differences between the two is recommended.

Further research is recommended on the cultural aspects of religion/spirituality in psychopathology. Grover, Davuluri, and Chakrabarti (2014) recommend that further exploration using a multicultural framework related to the roles of specific religious/spiritual experiences, beliefs, and behaviors is warranted. Integrating religious/spiritual cultural features into mainstream biological, medical, and psychological fields that support the assessment, diagnosing, and treatment processes would be better equipped to address beliefs and expressions of cultural and pathological phenomena.

To more fully understand the scope of the experiences clinicians have when distinguishing between religious/spiritual and psychotic phenomena more studies are recommended. More case studies may be beneficial as they provide analysis of distinct psychotic features, how those features manifest, and how they are categorized into cultural nonpathological features that are not in need of clinical treatment and clinical pathological features in need of clinical treatment. In addition, phenomenological studies may be beneficial as the personal and inner experience of the individual experiencing religious/spiritual and psychotic phenomena may be verbalized and analyzed.

Phenomenological studies may provide clinicians additional insight on distinguishing between the religious/spiritual and psychotic phenomena.

Another recommendation for future research includes discussions relating to the types of academic material and clinical training relating to religious/spiritual and psychotic phenomena as well as how clinicians are trained to discuss religious/spiritual and psychotic phenomena. Discussions including novice, intermediate, and experienced level clinicians' perspectives would be beneficial. Participants of this study were mostly social workers and licensed mental health associates. Since a broad range of professionals in the mental health field are likely to encounter the phenomenon of religion/spirituality and psychosis, it is recommended that future studies target clinicians with other training modalities such as doctoral level psychologists and psychiatrists.

Religious/spiritual phenomena may be a sensitive topic and challenging to address. Given the large religious and spiritual affiliations found in the general population further research and a press for clinical cultural competency including religion and spirituality are warranted (Rosmarin, Green, Pirutinsky & McKay, 2014). Clinical training including religious and spiritual competencies have a "rightful place" (Rosmarin, Green, Pirutinsky, & McKay, 2014, p. 195). Often culture competence is focused on gender, sexuality, race, and ethnicity; rarely does culture competence focus on religiosity and spirituality. Continuing education relating to religious and spirituality may support culture competence (Jacobs, 2010).

Social Change

Results of this study are potentially beneficial to clinicians when distinguishing overlapping religious/spiritual and psychotic phenomena. Mental health professionals may want to tailor clinical treatment to include thorough exploration of religious/spiritual cultural phenomena, both within typical demographics as well as the culture the client has chosen to believe and follow practices. Social change relating to addressing distinguishing overlapping phenomena relating to cultural features is desirable. I intend to distribute the results with the participants of the study and to publish the dissertation through free academic publishing websites.

Conclusion

Distinguishing phenomena in the diagnosis and treatment of psychotic disorders is critical in delivering clinical, cultural, and ethical treatment. With the increase in multicultural societies this study is relevant to community and clinical providers alike. The purpose of this study was to explore clinicians' perspectives when distinguishing between religious/spiritual and psychotic phenomena. I was successful in the endeavor to gain insight into clinician's conceptualizations in the similarities and differences between religious/spiritual and psychotic phenomena as well as gain insight to their actual process of distinguishing.

In this generic qualitative study, I addressed a gap in the literature regarding the "how to" process that clinicians use to distinguish between religious/spiritual and psychotic phenomena. Similar research exploring spiritual advanced individuals as well as the role of religion and spirituality in psychotic presentation (Bhargav, Jagnnathan,

Raghuram, Srinivasan & Gangadhar, 2015; Grof, & Grof, 1989; Grof, 2006; Grof & Grof 2017; Valanciute & Thampy, 2011) guided me in this study. Understanding how clinicians distinguish between religious/spiritual and psychotic phenomena was central in this study.

Through this study, three themes were created: trauma is important to consider when exploring religious/spiritual and psychotic phenomena; clinical practice is multifaceted; and similar language is used to describe religious/spiritual and psychotic phenomena. As I set out to gain insight into how clinicians distinguish between religious/spiritual and psychotic phenomena, I was surprised to discover the attention to the role of trauma and trauma related symptoms. The role of trauma became the most saturated and prevalent theme in this study.

In this study, clinicians were given opportunities to voice their clinical and personal views. Clinicians who participated in this study expressed a substantial desire to be a culturally competent clinician as well as promote being a culturally competent clinician to colleagues. I hope that my dissertation makes a positive contribution to the field of psychology in the clinical assessment and mental health treatment to those experiencing religious/spiritual and psychotic phenomena.

References

Adan-Manes, J., & Ramos-Gorostiza, P. (2016). On the notion of psychosis: Semantic and epistemic concerns. *Journal of Psychopathology*, *22*(2), 110–117.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author. https://doi.org/10.1176/appi.books.9780890425596

Barbieri, I., Zani, B., & Sonn, C. (2014). Meanings of community in contexts of multiculture: The role of citizenship, identity, and cultural changes. *Journal of Community Psychology*, *42*(8), 980–996. https://doi.org/10.1002/jcop.21666

Barton, E. J. (2011). Movement and mindfulness: A formative evaluation of a dance/movement and yoga therapy program with participants experiencing severe mental illness. *American Journal of Dance Therapy*, *33*(2), 157–181. https://doi.org/10.1007/s10465-011-9121-7

Benning, T. B., Harris, K. P., & Rominger, R. (2019). Delayed diagnosis of the physio-kundalini syndrome: Case report and literature review. *Spirituality in Clinical Practice*, 6(3), 194–212. https://doi.org/10.1037/scp0000186

Bersoff, D. (2014). *Ethical conflicts in psychology* (4th ed.). Washington, DC.: American Psychological Association.

Bhargav, H., Jagannathan, A., Raghuram, N., Srinivasan, T. M., & Gangadhar, B. N. (2015). Schizophrenia patient or spiritually advanced personality? A qualitative case analysis. *Journal of Religion and Health*, *54*(5), 1901–1918. https://doi.org/10.1007/s10943-014-9994-0

Blazer, D. G. (2009). Religion, spirituality, and mental health: What we know and why this is a tough topic to research. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie*, *54*(5), 281–282. https://doi.org/10.1177/070674370905400501

Bourke, B. (2014). Positionality: Reflecting on the research process. *The Qualitative Report*, *19*(33), 1-9. Retrieved from http://nsuworks.nova.edu/tqr/vol19/iss33/3

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbooks in psychology®. APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (p. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

Caelli, K., Ray, L., and Mill, J., (2003). Clear as mud: Toward greater clarity in generic qualitative research. *International Institute for Qualitative Methodology.* https://doi.org/10.1177/160940690300200201

Coa, G. (2007). The pattern matching rôle of systems thinking in improving research trustworthiness. *Systematic Practice and Action Research, 20*(6), 441453. https://doi.org/10.1007/s11213-007-9069-1

Charmaz, K. (2004). Grounded theory. In S. N. Hesse-Biber & P. Leavy, *Approaches to qualitative research* (pp. 495-521). New York: Oxford University Press.

Clarke, V. (2017, December 9). *What is thematic analysis?* [Video file]. Retrieved from https://www.youtube.com/watch?v=4voVhTiVydc&t=432s

Clarke, V. (2018, June 25). *Thematic analysis, an introduction.* [Video file]. Retrieved from https://www.youtube.com/watch?v=5zFcC10vOVY&t=1946s

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling & Psychotherapy Research*, *18*(2), 107–110. https://doi.org/10.1002/capr.12165

Corey, G. (2009). *Theory and practice of counseling and psychotherapy*. Belmont, CA: Brooks/Cole Cengage Learning.

Creswell, J. (2009). *Research design: qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: SAGE.

Creswell, J. (2013). *Qualitative inquiry and research design choosing among five approaches* (3rd ed.). Thousand Oaks, CA: SAGE.

Cullberg, J. (2011). Psychosis, dissociation or delirium? Observations on the importance of differential diagnostics. *Psychosis: Psychological, Social and Integrative Approaches*, *3*(2), 160–162. https://doi.org/10.1080/17522439.2010.518321

Delaney, H. D., Miller, W. R., & Bisonó, A. M. (2013). Religiosity and spirituality

among psychologists: A survey of clinician members of the American Psychological Association. *Spirituality in Clinical Practice*, *1*(S), 95–106. https://doi.org/10.1037/2326.4500.1.S.95

DeTore, N. R., Gottlieb, J. D., & Mueser, K. T. (2019). Prevalence and correlates of PTSD in first episode psychosis: Findings from the RAISE-ETP study. *Psychological Services*. https://doi.org/10.1037/ser0000380

Flanagan, A. (2018A). Conducting culturally sensitive psychosocial research. NetCE. Sacramento, CA. http://www.netce.com/1597/Course_96592.pdf

Flanagan, A. (2018B) Cultural meanings of death and dying. NetCE. Sacramento, CA. https://www.netce.com/

Frankl, V. (1992). *Man's search for meaning: An introduction to logotherapy.* Boston, MA: Beacon Press. (Originally published in 1946)

Galek, K., Flannelly, K. J., Ellison, C. G., Silton, N. R., & Jankowski, K. R. B. (2015). Religion, meaning and purpose, and mental health. *Psychology of Religion and Spirituality*, *7*(1), 1–12. https://doi.org/10.1037/a0037887

Gibson, L. E., Alloy, L. B., & Ellman, L. M. (2016). Trauma and the psychosis spectrum: A review of symptom specificity and explanatory mechanisms. *Clinical Psychology Review*, *49*, 92–105. https://doi.org/10.1016/j.cpr.2016.08.003

Glover, J., & Friedman, H., (2015). *Transcultural competence: Navigating cultural differences in the global community*. Washington, DC: American Psychological Association.

Goretzki, M., Thalbourne, M. A., & Storm, L. (2013). Development of a spiritual

emergency scale. *Journal of Transpersonal Psychology*, *45*(2), 105–117.

Grof, S., & Grof, C. (1989). *Spiritual emergency: When personal transformation becomes a crisis*. Los Angeles: Tarcher Press.

Grof, S., (2006). *When the impossible happens: Adventures in non-ordinary realities.* Boulder, CO: Sounds True, Inc.

Grof, C., & Grof, S. (2017). Spiritual emergency: The understanding and treatment of transpersonal crises. *International Journal of Transpersonal Studies*, 36 (2). https://doi.org/10.24972/ijts.2017.36.2.30

Grover, S., Davuluri, T., & Chakrabarti, S. (2014). Religion, spirituality, and schizophrenia: a review. *Indian Journal of Psychological Medicine*, *36*(2), 119–124. https://doi.org/10.4103/0253-7176.130962

Hays, D., & Erford, B., (2010). *Developing multicultural counseling competence: A systems approach.* Upper Saddle River, NJ: Pearson Education, Inc.

Heppner, P. P., Wang, K. T., Heppner, M. J., & Wang, L.-F. (2012). From cultural encapsulation to cultural competence: The cross-national cultural competence model. In N. A. Fouad, J. A. Carter, & L. M. Subich (Eds.), *APA handbook of counseling psychology, Vol. 2: Practice, interventions, and applications.* (pp. 433–471). Washington, DC: American Psychological Association. https://doi.org/10.1037/13755-018

Henry, H. M. (2015). Spiritual energy of Islamic prayers as a catalyst for psychotherapy. *Journal of Religion and Health*, *54*(2), 387–398. https://doi.org/10.1007/s10943-013-9780-

Hibbard, W. (2007). The Native American sweat lodge ceremony: Reports of transpersonal experiences by non-native practitioners. *Journal of Transpersonal Psychology*, *39*(1), 68–91.

Huguelet, P. & Koenig, H. (2009). Introduction: Key Concepts. In Huguelet, P., & Koenig, H., *Religion and Spirituality in Psychiatry.* (pp. 1-5). New York, NY: Cambridge University Press.

Huguelet, P., & Mohr, S., (2009). Religion/spirituality and psychosis. In Huguelet, P., & Koenig, H. *Religion and Spirituality in Psychiatry.* (pp. 65-80). New York, New York: Cambridge University Press.

Hustoft, H., Hestad, K. A., Lien, L., Møller, P., & Danbolt, L. J. (2013). "If I didn't have my faith I would have killed myself!": Spiritual coping in patients suffering from schizophrenia. *International Journal for the Psychology of Religion*, *23*(2), 126–144.

https://doi.org/10.1080/10508619.2012.688003

Ishibashi, N. (2005). Barrier or bridge? The language of diagnosis in clinical social work. *Smith College Studies in Social Work*, *75*(1), 65–80. https://doi.org/10.1300/J497v75n01_05

Jacobs, C. (2010). Exploring religion and spirituality in clinical practice. *Smith College Studies in Social Work*, *80*(2–3), 98–120. https://doi.org/10.1080/00377317.2010.486358

Janesick, V. (2011). *Stretching exercises for qualitative researchers* (3rd ed.). Thousand Oaks, CA: Sage.

Kahlke, R. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods* http://creativecommons.org/licenses/by-nc-sa/4.0/

Kleiger J. and Khadivi, A., (2015). *Assessing psychosis. A clinicians guide*. New York, New York. Routledge. https://doi.org/10.4324/9781315882086

Knabb, J. J. (2012). Centering prayer as an alternative to mindfulness-based cognitive therapy for depression relapse prevention. *Journal of Religion and Health*, *51*(3), 908–924. https://doi.org/10.1007/s10943-010-9404-1

Knabb, J. J., & Wang, K. T. (2019). The communion with God scale: Shifting from an etic to emic perspective to assess fellowshipping with the triune God. *Psychology of Religion and Spirituality*. https://doi.org/10.1037/rel0000272

Koenig, H., (2007). Religion, spirituality and psychotic disorders. *Archives of Clinical Psychiatry* (São Paulo), 34(Suppl. 1), 95-104. https://doi.org/10.1590/S0101-60832007000700013

Koenig, H., (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatry.* 2009;54(5):283–291. https://doi.org/10.1177/070674370905400502

Lukoff, D., & Lu, F., (1988). Mystical experience: Transpersonal research review. *The Journal of Transpersonal Psychology.* 1988 Volume 20. No. 2. https://pdfs.semanticscholar.org/9456/947ce566767d68cd9f6e0b4e3a6fe1287a67.pdf

Medicine Net, (2018). Mental disorders in America.

https://www.medicinenet.com/script/main/art.asp?articlekey=21466

Menezes, A., & Moreira-Almeida, A. (2010). Religion, spirituality, and psychosis. *Current Psychiatry Reports* 12, 174-179. https://doi.org/10.1007/s11920-010-0117-7

Mirza, A., Birtel, M. D., Pyle, M., & Morrison, A. P. (2019). Cultural differences in psychosis: The role of causal beliefs and stigma in White British and South Asians. *Journal of Cross-Cultural Psychology,* 50(3), 441–459. https://doi.org/10.1177/0022022118820168

Mohr, S., Borras, L., Rieben, I., Betrisey, C., Gillieron, C., Brandt, P.-Y. … Huguelet, P. (2010). Evolution of spirituality and religiousness in chronic schizophrenia or schizo-affective disorders: A 3-years follow-up study. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *45*(11), 1095–1103. https://doi.org/10.1007/s00127-009-0151-0

Mohr, S., & Huguelet, P., (2009). Religious and spiritual assessment in clinical practice. In Huguelet, P., & Koenig, H. *Religion and Spirituality in Psychiatry.* (pp. 232-243). New York, New York: Cambridge University Press. https://doi.org/10.1017/CBO9780511576843.016

Moreira-Almeida, A., Koenig, H. G., & Lucchetti, G. (2014). Clinical implications of spirituality to mental health: Review of evidence and practical guidelines. *Revista Brasileira de Psiquiatria*, *36*(2), 176–182. https://doi.org/10.1590/1516-4446-2013-1255

Mueller, J. (2012) Understanding the atheist college student: A qualitative examination, *Journal of Student Affairs Research and Practice,* 49:3, 249-266, https://doi.org/10.1515/jsarp-2012-6439

Murray, E. D., Cunningham, M. G., & Price, B. H. (2012). The role of psychotic disorders in religious history considered. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *24*(4), 410–426. https://doi.org/10.1176/appi.neuropsych.11090214

Murphy, M. A. (2000). Coping with the spiritual meaning of psychosis. *Psychiatric Rehabilitation Journal*, *24*(2), 179–183. https://doi.org/10.1037/h0095101

National Alliance on Mental Illness, (2018). Early psychosis and psychosis. Arlington, VA: Author. https://www.nami.org/earlypsychosis.

Palaganas, E., Sanchez, M., Molintas, M., & Caricativo, R. (2017). Reflexivity in qualitative research: A journey of learning. *The Qualitative Report,* 22(2), 426-438. Retrieved from https://nsuworks.nova.edu/tqr/vol22/iss2/5

Patton, M., (2015). *Qualitative research & evaluation methods*. 4th Ed. Thousand Oaks, CA: Sage

Phillips, R. E., III, Lukoff, D., & Stone, M. K. (2009). Integrating the spirit within psychosis: Alternative conceptualizations of psychotic disorders. *Journal of Transpersonal Psychology*, *41*(1), 61–80.

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology*, *65*(2), 131–146. https://doi.org/10.1002/jclp.20563

Raheim, S., & Lu, J. J. (2014). Preparing MSW students for integrative mind–body-spirit practice. *Clinical Social Work Journal*, *42*(3), 288–301. https://doi.org/10.1007/s10615-014-0484-3

Rapsomatioti, G. (2014). Spirituality and the psychotic subject on the thought of Lacan. *Insanity and Divinity. Studies in Psychosis and Spirituality*. (pp. 196-208). Edited by John Gale, Michael Robson, and Georgia Rapsomatioti. New York, New York, Routledge.

Renard, S. B., Huntjens, R. J. C., Lysaker, P. H., Moskowitz, A., Aleman, A., & Pijnenborg, G. H. M. (2017). Unique and overlapping symptoms in schizophrenia spectrum and dissociative disorders in relation to models of psychopathology: A systematic review. *Schizophrenia Bulletin*, *43*(1), 108–121. https://doi.org/10.1093/schbul/sbw063

Roxburgh, E. C., & Evenden, R. E. (2016). 'They daren't tell people': Therapists' experiences of working with clients who report anomalous experiences. *European Journal of Psychotherapy & Counselling*, 18(2), 123–141. https://doi.org/10.1080/13642537.2016.1170059

Saldana, J. (2009). *The coding manual for qualitative researchers*. (pp. 1-31). Thousand Oaks, CA. Sage Publications.

Sandelowski, M., (2000) Focus on research methods: Whatever happened to qualitative description? *Research in Nursing and health, University of North Carolina*. 2000, 23, 334-340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sharma, T., Kumari, P., & Kumar, V. (2017). Yoga and mental health: A review. *Journal of the Indian Academy of Applied Psychology*, *43*(1), 128–133.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63-75. https://doi.org/10.3233/EFI-2004-22201

Smolak, A., Gearing, R. E., Alonzo, D., Baldwin, S., Harmon, S., & McHugh, K. (2013). Social support and religion: Mental health service use and treatment of schizophrenia. *Community Mental Health Journal*, *49*(4), 444–450. https://doi.org/10.1007/s10597-012-9536-8

Sood, A. (2016). The global mental health movement and its impact on traditional healing in India: A case study of the Balaji temple in Rajasthan. *Transcultural Psychiatry*, *53*(6), 766–782. https://doi.org/10.1177/1363461516679352

Srinivasan, T. M. (2016). Yoga and physical exercise. *International Review of Psychiatry*, *28*(3), 241. https://doi.org/10.1080/09540261.2016.1188786

Starnino, V. R. (2016). When trauma, spirituality, and mental illness intersect: A qualitative case study. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(3), 375–383. https://doi.org/10.1037/tra0000105

Ting, R. S. K. (2012). The worldviews of healing traditions in the East and West: Implications for psychology of religion. *Pastoral Psychology*, *61*(5–6), 759–782. https://doi.org/10.1007/s11089-012-0439-y

Transpersonal Project. (2014, February 2). *Stanislav Grof The Healing Potential of Non-Ordinary States of Consciousness* [Video File]. Retrieved from

https://www.youtube.com/watch?v=La9qnPwx3Nc&t=805s

Treatment Advocacy Center. (2015). Schizophrenia – fact sheet. Arlington, VA. https://www.treatmentadvocacycenter.org/component/content/article/187-behind-the-facts/25-schizophrenia-fact-sheet

Treatment Advocacy Center (2018). Research weekly: The high cost of schizophrenia. Arlington, VA. http://www.treatmentadvocacycenter.org/key-issues/public-service-costs/3599-research-weekly-the-high-cost-of-schizophrenia.

Valanciute, A., & Thampy, L. A. (2011). Physio kundalini syndrome and mental health. *Mental Health, Religion & Culture*, *14*(8), 839–842. https://doi.org/10.1080/13674676.2010.530648

Veling, W., Counotte, J., Pot-Kolder, R., van Os, J., & van der Gaag, M. (2016). Childhood trauma, psychosis liability and social stress reactivity: A virtual reality study. *Psychological Medicine*, *46*(16), 3339–3348. https://doi.org/10.1017/S0033291716002208

Vieten, C., Scammell, S., Pierce, A., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2016). Competencies for psychologists in the domains of religion and spirituality. *Spirituality in Clinical Practice*, *3*(2), 92–114. https://doi.org/10.1037/scp0000078

Wang, D., & Chan, A. (2014). Didn't we stop thinking that mental illness was caused by the devil? Revisiting the topic of psychosis and spirituality. *Psyccritiques,* 59(24), https://doi.org/10.1037/a0036590

Wellman, J. K., Jr., Corcoran, K. E., & Stockly, M. K. (2014). "God is like a drug…":

Explaining interaction ritual chains in American megachurches. *Sociological Forum*, *29*(3), 650–672. https://doi.org/10.1111/socf.12108

Whaley, A. L., & Hall, B. N. (2009). Effects of cultural themes in psychotic symptoms on the diagnosis of schizophrenia in African Americans. *Mental Health, Religion & Culture*, *12*(5), 457–471. https://doi.org/10.1080/13674670902758273

Whitley, R. (2012). Religious competence as cultural competence. *Transcultural Psychiatry*, *49*(2), 245–260. https://doi.org/10.1177/1363461512439088

Appendix A: Screening Form

Screening Information

1. What is your current clinical role as a licensed mental health professional?

2. Have you personally experienced distinguishing between religious, spiritual, and psychotic phenomena?

3. Do you speak English fluently?

Appendix B: Demographic Form

1. Age,

2. Gender

3. Years of experience in the mental health field

4. Title/degree

5. Current position (and/or role).

6. Clinical population/specialization

Appendix C: Recruitment Flyer

Will you please help me to find participants for my study and share this recruitment?

U.S. Licensed Mental Health Professionals Needed for a Research Study:

Clinicians' Perspectives on Distinguishing between Religious/Spiritual and Psychotic Phenomena

- Are you a licensed mental health professional in the United States of America?
- Have you distinguished between religious, spiritual, and psychotic phenomena?

I am PhD Student conducting a research study to understand how clinicians distinguish between religious, spiritual, and psychotic phenomena.

What is Involved

Interviews last between 30 and 90 minutes. Each participant will be asked to share their experiences relating to the "how-to" distinguishing process between religious, spiritual, and psychotic phenomena as well as how clinicians engage in conversations with their clients about religious, spiritual, and psychotic phenomena.

There is a $10 Starbucks gift card for compensation for participating in this study.

If you meet these requirements and would like to help with this research study, please contact me via email at Jessica.parker2@waldenu.edu. If you know someone that meet these requirements and would like to participate in the study, please forward this post to them.

This study has been reviewed and approved by the IRB of Walden University.

Approval number 06-28-19-0574071

Appendix D: Interview Questions

Participants ID: _____

Date of Interview: _____

Location of Interview: _____

RQ1. How do clinicians describe their understanding of clients' religious and spiritual experiences and beliefs as distinct symptoms from psychotic symptoms needing clinical care/treatment?

1. Describe your understanding of psychosis and if it has evolved over time.

2. How do you distinguish religious and spiritual phenomena from psychotic phenomena?

3. Think back and please describe 1-2 occurrences when religious, spiritual, and psychotic phenomena were difficult to disentangle.

4. Describe a time when religion and spirituality presented as psychotic. If so, how did you distinguish?

5. Describe a time when psychosis presented as religious and spiritual. If so, how did you distinguish?

6. Have you had a client who was experiencing psychosis and religious and spiritual phenomena simultaneously? If so, how did you distinguish?

RQ2. How do clinicians engage in conversation and explore their clients' religious and spiritual experiences and beliefs and psychotic symptoms needing clinical care/treatment?

1. How do you start a dialogue w/ clients when exploring their R/S beliefs and experiences?

2. When a client presents with R/S that you are familiar/ unfamiliar with, how do you broach the subject?

3. What kind of conversations w/ clients have been the most fruitful when distinguishing R/S/P phenomena? The least fruitful?

4. Have you ever not told a client the diagnostic decision to identify a R/S feature as psychosis? Why or why not?

5. Have you ever disagreed with a client relating to R/S as psychosis? If so, describe the process and outcome.

Final Questions:

Is there anything else about your distinguishing processes that you would like to share? Anything I have not addressed during this interview?

Thank you for taking the time to answer these questions today.