Coming Alongside St. Anthony in the Desert: How Mental Health Practitioners can Best Support Individuals Experiencing Psychosis with Religious and Spiritual Themes.

by

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Abstract

Religious and/or spiritual (R-S) beliefs and practices are often highly important in the lives of those experiencing psychosis. Often, individuals with psychosis will utilize aspects of their R-S beliefs and practices to cope with distressing aspects of their illness, and at the same time, the hallucinations and delusions that accompany psychosis often contain R-S themes. Despite the potential benefits of engaging with R-S beliefs and practices, a lack of R-S competency among mental health practitioners can seriously hinder appropriate assessment and treatment planning. This paper offers practical guidelines for mental health practitioners to effectively support these individuals, recognizing the significance of R-S beliefs and practices in their experiences and recovery.

Keywords: cultural competency, psychosis, schizophrenia, spiritual care, religious and spiritual coping, religion and spirituality, substance-induced psychosis, treatment planning

Dedication

Dedicated to A, and all of the other young people looking for God in the halls of a psych ward.

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Chapter 1

Introduction

The treatment of psychosis is generally associated solely with pharmaceutical interventions, however, there is substantial research indicating psychosocial interventions are also highly important. Evidence suggests psychoeducation, family programs, social skills training and various psychotherapies can all prevent relapse and manage symptoms (Chien et al., 2013; Frawley et al., 2023). Psychosis itself is a complex phenomenon, present in a variety of diagnoses, with a broad range of symptoms. Symptoms range from delusions (fixed beliefs unchanged by opposing evidence), hallucinations (the perception of stimuli which are not actually present), disorganized thoughts, speech, and movement as well as “negative symptoms,” characterized by a lack of emotion, motivation, speech or movement (American Psychiatric Association [APA], 2013). Among the vast range of psychotic experiences, religious and spiritual themes are not uncommon. “Religious psychosis” as defined by Rosmarin (2018), is simply psychosis with the presence of R-S[1] themes (p. 52). This could include R-S delusions, such as “a belief that one is being persecuted or controlled by spiritual entities” (Rosmarin, 2018, p. 52). It may also include R-S hallucinations, such as hearing the voice of God, or seeing angels, demons, or other religiously themed visuals (Rosmarin). Considering the prevalence of R-S related symptoms in psychotic disorders, it is pertinent psychosocial treatments can also address the R-S beliefs and practices of individuals experiencing psychosis.

Purpose Statement

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[1] Religious and/or Spiritual

The experience of psychosis is a relatively prevalent human experience: It is estimated that every 3 out of 100 people will experience psychosis at some point during their lifetime (Bromley et al., 2015). According to Rosmarin (2018), “spiritual symptoms” are not uncommon either: “case reports of excessive religious behaviour among mood-disordered patients are frequently cited in the scientific record as far back as the early 1900s” (p. 52). Current estimates indicate up to 22% of patients with bipolar and 39% of patients with schizophrenia experience R-S delusions (Rosmarin, 2018). Given the prevalence of these symptoms, and the fact that non-pharmaceutical interventions have been indicated as an important factor in the treatment of psychosis, it is highly pertinent that mental health practitioners know how to appropriately address and work with the R-S beliefs and practices of those experiencing psychosis. This project will aim to demonstrate how mental health practitioners can best come alongside this population, by exploring topics such as how to assess R-S beliefs and practices among clients, individual and systemic consequences of R-S incompetency on behalf of practitioners, as well as how mental health practitioners can safely and appropriately discuss, and potentially incorporate, R-S beliefs and practices into treatment.

Contribution to the Field

According to Milevsky and Eisenberg (2012, as cited in Rosmarin et al., 2013) mental health practitioners are “best positioned” to support religious/spiritual clients when they possess diverse knowledge of R-S beliefs, practices, and traditions (p. 430). Unfortunately, the literature indicates that many practitioners lack the skills and knowledge to address and incorporate the R-S aspects of a client’s life. According to Rosmarin et al., (2013), evidence indicates that over two thirds of mental health professionals report “little-to-no clinical training” in religion and/or

spirituality, and one quarter feel significant discomfort when discussing R-S beliefs with clients (Rosmarin et al., 2013, 430). The literature indicates a lack of R-S competency can lead to serious consequences, including discrimination, inaccurate diagnoses, and misguided treatment (Adenponle et al., 2012; Nazroo, et al., 2020; O'Connor and Vandenberg, 2005). In the same way cultural competency is an important aspect of effective mental health treatment, R-S competency is equally as important to provide adequate care to individuals within the mental health system. Fortunately, research indicates that mental health clinicians have a desire to gain R-S competency: According a study conducted by Rosmarin et al. (2013), half of the practitioners they interviewed reported a "high level of interest" in receiving training related to addressing the R-S beliefs of clients. Clinical training in the realm of spirituality, religiosity, and psychosis with R-S themes is thus a highly pertinent issue.

Personal Positioning

I am a white, cisgender woman living on the unceded and traditional territories of the Musqueam, Squamish, and Tsleil-Waututh peoples in Vancouver, BC. While I am personally fascinated by the topics of religion and spirituality, I was not raised in a religious household and do not adhere to any specific faith tradition. It is important to note that much of my passion for this topic was fed by my work as a support-worker on an inpatient psychiatric unit, whereby I worked closely with many clients experiencing psychosis with R-S themes. Through this work, I had the opportunity to observe firsthand the prevalence of cultural and R-S incompetency, and the effect such incompetency can have on outcomes for individuals and their families. In the following paragraphs I will highlight some of my experiences in this work, to showcase why I believe this project is important.

As a support worker, I had the chance to observe many patients[2] with psychosis with R-S themes. These included patients who believed they could hear the voice of God, or other significant religious figures such as Jesus, Muhammed or the Devil. Some patients believed they were the second coming of Christ, or that they were sent to the world to convert others to their specific faith path. I have observed patients who believed they could see angels, demons, or Erinyes[3], could repel black magic that had been placed upon them by clinical staff or other patients, or could absorb psychic energy from staff, other patients, or crystals.

From my anecdotal observations, it is clear to me that R-S beliefs and practices play a significant role for those experiencing psychosis. What was even more striking however, was the way the clinical staff both discussed and worked with these clients. According to the DSM-V, it is pertinent for clinicians to consider an individual’s culture and faith background when assessing or working with said individual (APA, 2013). Unfortunately, I witnessed vast gaps in knowledge, as well as overt discrimination towards these patients. For example, a psychiatric nurse encouraging a Muslim patient to break her fast during Ramadan, or a white social worker challenging an Indigenous patient’s spiritual beliefs about environmental issues. This lack of competency did not only impact the interactions staff had with patients, but the way staff actually *assessed* these patients. For example, in Shia Islam specifically, it is not abnormal to perform certain rituals of self-flagellation, including beating one’s chests with the hands, to commemorate the martyrdom of the grandson of the Prophet, Husayn ibn ‘Ali (Dogra, 2019). It did not strike

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[2] All patients/clients discussed in this paper will have identifying information altered or omitted as to protect their identity.

[3] Beings described in various Greek myths and plays, often portrayed as winged women associated with darkness, death and madness (Aguirre, 2010).

me as particularly bizarre then when one Shia patient experiencing psychosis with R-S themes occasionally hit their chest with their hands in such a fashion. Other clinical staff however were unaware that this was a religious practice, and the patient's behaviour was automatically perceived as aggressive, and even as a form of self-injury. Lastly, it was evident to me that the clinical staff did not necessarily see the potential for R-S practice or belief to be a *protective factor* in lives of their patients. For example, one patient was admitted with substance-induced psychosis with R-S themes brought about by cannabis use. As with many of the patients with this type of presentation, staff were generally discouraged from discussing R-S beliefs with this patient. It struck me as highly counterproductive that I was discouraged from discussing the patient's R-S beliefs even when he shared that his relationship with his faith tradition was his main motivation for *not* using cannabis, an *extremely* important factor in the patient's recovery from his psychosis. While R-S beliefs may be pathological in the context of psychosis, I also witnessed that they can play an extremely important role in recovery.

Key Terms

Mental Health Practitioner

Any individual working directly with clients in the field of mental health. This could include but is not limited to registered clinical counsellors, support workers, social workers, occupational therapists, psychologists, psychiatrists or psychiatric nurses.

New Age

New Age is a catch-all term which will refer to a vast number of practices rooted in Western esotericism, and often associated with "spiritual themes and occultist influences" born

from the 1970s (Peters, 2022, p. 1612). Practices may include crystal healing, yoga, meditation, psychic healing, and astrology.

Psychosis

Psychosis here will refer to the variety of experiences and symptoms associated with the specific diagnoses outlined on pages 87- 122 in the DSM-V (APA, 2013). This could include but is not limited to experiences and symptoms associated with schizophrenia, schizophrenia spectrum disorder, medication/substance induced psychosis, and unspecified psychotic disorder.

Religion/Spirituality (R-S)

Religion and spirituality will refer to an individual's practices and beliefs associated with both formal and informal sects of religious or spiritual practice. This could include but is not limited to practices and beliefs related to Islam, Christianity, Sikhism, Hinduism, Paganism, Judaism or Indigenous Traditions. "Religious" and "Spiritual" (shorthanded as "R-S") will be used interchangeably, although the former is generally more closely associated with formal religious practice, whereas the latter is associated with individualized beliefs and practices not associated with a specific faith tradition.

R-S Competency

Sue et al., (2009) define cultural competency as the ability of a mental health practitioner to provide their services effectively to clients of diverse cultural backgrounds. R-S competency will thus be defined as the ability of a mental health practitioner to provide their services effectively to all clients, regardless of their R-S background, beliefs, or practices. This includes the ability to provide adequate assessment, psychoeducation, and treatment.

R-S Experience

R-S experience will refer to a definition provided by Walter and Koenig (2023) in their recent article *The Induction of Religious Experiences and Temporal Lobe Activation: Neuronal Source Localization Using EEG Inverse Solutions* as "special experiences [that] are mentally set apart from more ordinary ones and connected to theological constructs," wherein the experience must be subjectively "*deemed* religious" by the individual experiencing it (p. 1191). This definition covers a broad range of experiences, from a mere "feeling" of spiritual connection, to the vivid sensory experiences potentially associated with psychosis.

R-S Incompetency

Similarly, R-S incompetence will refer to the *inability* of mental health practitioners to provide their services effectively to clients of diverse R-S backgrounds, potentially leading to poor outcomes for clients.

Outline

Chapter 2 of this project will fall into 4 distinct subheadings: *R-S Experience*, *Psychosis*, *R-S Incompetency*, and lastly, *R-S Competency and How Mental Health Practitioners Can Best Serve Those with Psychosis with R-S Themes. R-S Experience* will give a brief overview of the importance of direct experience across R-S traditions, as well as explore the neurological components of R-S experience. *Psychosis* will provide a historical account of Western perspectives on psychosis, as well as modern Western perspectives, including the criteria found in the *Diagnostic and Statistical Manual 5* (DSM-V), aetiology, treatment, and lastly, non-Western perspectives on psychosis, and accompanying R-S experience. It also explores the prevalence of R-S themes in psychosis, the content of these experiences, and how these individuals may use religion and/or spirituality to cope. The fourth subheading, *R-S*

Incompetency will briefly examine the lack of understanding and discrimination that exists within the Western medical model against individuals experiencing psychosis with R-S themes, and the ways in which such incompetency can get in the way of positive outcomes for individuals. Lastly, *R-S Competency and How Mental Health Practitioners Can Best Serve Those with Psychosis with R-S Themes* will delve into what it means for mental health practitioners to gain R-S competency, and the most effective ways to work with individuals with R-S psychosis to produce positive outcomes for said individuals.

Chapter 3 of this project will consist of a discussion of the above findings, as well as a resource pamphlet for mental health practitioners. This pamphlet will summarize the findings from this capstone in a succinct and easy to understand format. The goal of this resource will be to provide mental health practitioners with the information they need to begin to gain R-S competency in relation to their clients.

Chapter 2

R-S Experience

> When he [Saint Anthony] was living hidden away in a tomb, a crowd of demons tore at him so savagely that his servant thought he was dead and carried him out on his shoulders. Then all who had come together mourned him as dead, but he suddenly regained consciousness and had his servant carry him back to the aforementioned tomb. There, lying prostrated by the pain of his wounds, in the strength of his spirit he challenged the demons to renew the combat. They appeared in the forms of various wild beasts and tore at his flesh cruelly with their teeth, horns, and claws. Then of a sudden a wonderful light shone in the place and drove all the demons away, and Anthony's hurts were cured. Realizing that Christ was there, he said: "Where were you, O good Jesus, where were you? Why did you not come sooner to help me and heal my wounds?" The Lord answered: "Anthony, I was here, but I waited to see how you would fight. Now, because you fought manfully, I shall make your name known all over the earth." (De Voragine, 1265/2012, p. 93-94).

This account of Saint Anthony can be found in *The Golden Legend*, originally compiled by Jacobus De Voragine around the year 1260 (1265/2012, p. xi). The original biography of St. Anthony, known as the *Vita Antonii*, from which De Voragine derived the story, was written by Athanasius of Alexandria in the 4th century, not longer after St. Anthony's death (Görg, 2011). The various accounts of St. Anthony, one of the original "Desert Fathers" (Görg) often depict vivid and seemingly psychedelic experiences with demons: Anthony was said to have seen demons in the form of seductive women, a child, and a variety of animals, including "lions,

bears, leopards, bulls, serpents, asps[4], scorpions, and wolves" (Athanasius, p. 188, 1891/362). While such dramatic sensory experiences are arguably no longer normalized in many mainstream R-S practices, they are a historically common phenomenon at the core of many established R-S traditions. In Genesis, both angels of God, and God Himself, are said to have appeared repeatedly to Abraham, providing him with direct, audible instruction. Prior to the initial revelation of the Qur'an to the Prophet Muhammed by the Archangel Jibril (Gabriel) [5], it was said the Prophet "witnessed visions so accurate that they seemed to materialize from the very fabric of reality" (Al-A'zami, 2003, p. 25). These included "a rock saluting him," the Archangel Jibril "calling him from the sky by name" and seeing a light (Al-A'zami, p. 25). According to the Sikh faith, Guru Nanak[6] began preaching after having a mystical experience in which he submerged himself in a river and conversed with God directly (Kapur, 2001). Regardless of whether one believes in the existence of God, or that such experiences are caused by said God, it is evident that such phenomenon, at one time, served as the catalyst for many widely regarded faith traditions.

Neurological Components of R-S Experience

For Carl Jung (1964), religion was yet another human phenomenon present in the *collective unconscious*, a universal set of archetypes and motifs which can be found "more or less the same everywhere and in all individuals" (p. 4). R-S concepts and motifs are thus universal phenomenon, which can be found both in the human psyche, *and* within the world. As

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[4] Snakes

[5] According to the Muslim tradition, the Qur'an was revealed to Muhammad, "bit by bit" over a period of 23 years (Al-A'zami, 2003, p. 45)

[6] The first Sikh Guru and founder of the Sikh faith (Kapur, 2001)

Jung explains “what is true of primitive lore is true in even higher degree of the ruling world religions” (p.7). For Jung, all of us have some sort of innate template for R-S experience, and while this specific idea may not be scientific in nature, the concept that humans possess some sort blueprint for R-S experience could certainly be. Over the past several decades various studies have been conducted to understand how R-S experience and neuroscience intersect. In the 1990’s, Andrew Newberg, an American neuroscientist would coin the term “Neurotheology,” leading various studies which attempted to locate God in the brain (Newberg, 2010). While the literature provides evidence for various brain regions associated with R-S experience, one of the most popularized hypotheses is the “temporal involvement hypothesis,” which posits that religious experience is the result of temporal lobe excitation (Walter & Koenig, 2023, p. 1191). According to Walter and Koenig, the temporal lobes are thought to be associated with auditory processing, memory, and emotion, as well as some visual processes, including object recognition. The temporal involvement hypothesis stems from the work of individuals such as Ruttan et al. (1990), d’Aquili and Newberg (1993) and Ramachandran (1998, as cited in Ratcliffe, 2003). In 1990, Ruttan et al. had participants don what would later be called the “God Helmet,” a device which used magnetic fields to stimulate the temporal lobes of subjects. According to Ruttan et al., this stimulation resulted in subjects often reporting subjective R-S experience. The work of V.S Ramachandran in the late 1990s arose from the continual observation that certain individuals suffering from temporal lobe epilepsy reported “profound religious feelings” during epileptic seizures: “[seizures can induce] deeply moving spiritual experiences, including a feeling of divine presence and the sense that they are in direct communion with God” (Ramachandran, 1998, as cited in Ratcliffe, 2003, p. 324-330). In 1998,

Ramachandran et al. (as cited in Ratcliffe, 2003) conducted a study in which they measured galvanic skin response of individuals with temporal lobe epilepsy to gauge their emotional reaction to various words. They found a “selectively enhanced response” to R-S words and imagery, and, compared with control subjects, a “diminished sensitivity” to other “emotive categories” such as sexual imagery (as cited in Ratcliffe, p. 325). Some of the most recent research on R-S experience in the brain was conducted by Walter and Koenig in 2023. They examined the brain activity of 60 participants who identified as evangelical Christians. Walter and Koenig helped induce R-S experience by playing a “religious worship song […] which had a personal track-record of helping [the participant] to sense God’s presence in worship,” while using an electroencephalogram (EEG) to measure neural activity (p.1195). Walter and Koenig concluded that the temporal lobe, specifically the right temporal lobe, was “significantly associated with the religious experience” (p. 1199). While it would be an oversimplification to conclude that the temporal lobe is the “source” of R-S experience within the human brain, research over the past several decades has allowed us to begin to outline a neurological blueprint for R-S experience, and there is significant evidence that the temporal lobes play an important role in this puzzle. According to Ng (2007) it is temporal lobe dysfunction, specifically “temporolimbic overactivity,” that is potentially responsible for both psychosis and the tendency of an individual experiencing psychosis “to interpret intense or discrepant perceptual events as spiritual” (p. 62). Being that the human brain arguably contains an inherent mechanism for R-S experience, it is no surprise that R-S experience often arises during experiences of psychosis.

Psychosis

A History of the Western Perspective

As discussed previously, R-S experiences lie the core of many widely accepted faith traditions. It is fair to assume that during the time of Abraham, St. Anthony, Muhammad, or Guru Nanak, direct R-S experiences such as seeing demons, angels, or hearing the voice of God were unlikely to be perceived as anything other than true, direct experience with a very real Godhead. Of course, with the advent of the Renaissance, the western world began to relinquish mystical thinking, and opt for alternative explanations. Many well-known thinkers and philosophers in the modern era shared their ideas about the source of religious experience: Individuals like Freud, Marx, and Nietzsche all argued religious experience was a symptom of a defect, whether it be from the individual's childhood, capitalism, or the mere weakness of man's nature, respectively (Freud, 1927/1961; Marx, 1843; Nietzsche, 1895/1990). For religious philosophers like Kierkegaard, hearing the voice of God provided an opportunity to take a "leap of faith," to disregard what is rational or reasonable, and demonstrate absolute belief (1843/2005). As the zeitgeist shifted to a more empirical, medical model, R-S experiences, i.e., hearing or seeing R-S stimuli that others could not, was more likely to be classified as a physiological defect. In his chapter *Psychosis* published in *The Routledge history of madness and mental health*, Noll (2017) explains language describing psychotic symptoms began to appear in the medical literature around the mid 1800s. While pin-pointing the exact advent of exact terminology proves to be difficult, Noll posits an argument made by British Psychiatrist and Historian German E. Berrios (1995, as cited in Noll, 2017). According to Noll, Berrios argues that "psychosis-as-syndrome" emerged from a "conceptual splitting of the ancient clinical syndrome of delirium in the 1880s in French and German psychiatry" (p. 336). In this way delirium, and it supposed organic aetiology, served as the "clinical model" for psychosis: "psychosis carried with it a biological heritage that

blurred the border between syndrome and disease. The more severe the symptoms, then the more deeply physical must be the origin" (Noll, 2017, p. 336-337). This understanding drove many of the subsequent understandings of psychosis and psychotic disorders, including Krapelin's "'whole body' psychoses of dementia praecox," Bleuler, who coined the term "schizophrenia," and for the later "'Heidelberg school' of German psychiatrist and philosopher Karl Jaspers" (Noll, 2017, p. 337). Of course, this explanation would also inform treatment throughout the 19th and 20th centuries. In the late 1800's, treatment was seemingly experimental, and consisted of surgery, organotherapy[7], and "many other somatic treatments" (Noll, para. 21). One barbarous example of such ineffective surgeries was presented by German Psychiatrist Karl Wilmanns who complained that his "implantation […] of a sound testicle in the abdominal cavity of a katatonic" was ineffective in alleviating the patient's symptoms (as cited in Noll, 2017, para. 21). Somatic treatments would remain the norm for the first half of the 20th century, characterized by institutionalization, the administration of experimental medications, electroconvulsive therapy, and even frontal lobe lobotomies for a brief period in the 1940s (Mander & Kingdon, 2015; Soares et al., 2013). By the 1950s, more effective antipsychotic medications, such as Thorazine, were being administered to patients (Mander & Kingdon, 2015). These medications generally reduced the "acute symptoms" of psychosis but failed to produce significant improvements in individual's ability to function (Mander and Kingdon, 2015, p. 64). The 60's however would bring about a cultural shift: It was Karl Jaspers who in the early 20th century had famously labelled psychosis, a nonunderstandable" phenomenon (Jaspers, 1913, as cited in Mander and Kingdon, 2015, p. 64). But by the 1960's clinicians such as R.D Laing challenged this

[7] Treatment of disease by the use of animal organ or their extracts (Merriam-Webster)

"nonunderstandable" quality, arguing instead that psychosis could be seen as an "understandable symbolic expression of distress" within a social framework (as cited in Mander and Kingdon, 2017, p. 64). R.D Laing, a radical Scottish psychiatrist, and key player in the "anti-psychiatry" movement (O'Hagan, 2012) boldly stated that there is "no such 'condition' as 'schizophrenia', but the label is a social fact and the social fact a *political event*" (Laing, 1967, p. 100). Laing was interested in the *content* of an individual's psychosis: "Jaspers […] tends to discount the patient's own construction" states Laing, "yet both the experience and construction may be valid in their own terms" (112). For Laing, the experience of someone in psychosis was not merely a "chaotic jumble of contents" (Jaspers, n.d., as cited in Laing, 1967), but a significant and comprehensible experience: R-S themes *were* worth paying attention to (Laing, 1967). Laing argued that the "transcendental experiences" which sometimes occur in psychosis were not unlike the experiences which "seem to […] be the original well-spring of all religions" (p. 108). He felt that often, R-S experiences were part of a necessary journey which needed to play out for an individual to come out the other side: "can we not see that this voyage is not what we need to be cured of, but that it is itself a natural way of healing our own appalling state of alienation called normality?" (Laing, p. 136). While Laing's radical ideas may have been extreme, the cultural pendulum swing would help shift the paradigm from psychosis as a purely organic disease, to a more nuanced and ethical understanding.

Modern Paradigms and The DSM-V

If 200 years of defining, and redefining, what has come to be called "psychosis" in the Western world has gotten us anywhere, it is arguably T*he Diagnostic and Statistical Manual 5* (DSM-V). The DSM-V, which is ironically referred to as the "Bible" of psychiatry (Jabr, 2013),

provides criteria for psychosis under the "Schizophrenia Spectrum and Other Psychotic Disorders" category (APA, 2013, p. 87). The DSM-V is considered an authority on psychiatric illness and is used by many practitioners today to diagnose and treatment plan for individuals in their care.

Criteria. The DSM-V provides 5 defining features of psychotic disorder, the first being *delusions* (APA). Delusions, explains the DSM-V, are "fixed beliefs" which do not change, even when contradictory evidence is presented (APA, p. 87). These most commonly include *persecutory* delusions, "the belief that one is going to be harmed [or] harassed," as well as *referential* delusions, the belief that "gestures, comments, environmental cues, and so forth" are directed, or *refer,* to oneself (APA, p.87). Delusions may also be classified as *grandiose*, belief that one has special abilities, *erotomanic,* belief that someone else is romantically interested in you, *nihilistic,* belief in impending catastrophe, and *somatic*, belief that there is something wrong with one's body (APA). The second feature outlined by the DSM-V is *hallucinations*, which they define as "perception-like experiences that occur without an external stimulus" (APA, p. 87). These can include visual hallucinations, i.e., seeing stimuli which others cannot, and audio hallucinations, i.e., hearing stimuli that others cannot, the latter being most common in schizophrenia (APA). The 3rd feature of psychosis outlined in the DSM-V is *disorganized thinking*, which they explain is identified through disorganized speech (APA). This can present as *derailment* (rapidly switching topics), *tangentiality* (an inability to stay on topic), or *incoherence* (non-sensical speech, also known as "word salad") (APA). Similarly, the DSM-V lists g*rossly disorganized or abnormal motor behaviour* as the 4th defining feature of psychosis (APA). This encompasses a wide variety of "abnormal" movement, and according to the DSM-V,

"problems may be noted in any form of goal-directed behaviour" (APA, p. 88). This also includes *catatonia*, defined as "a marked decrease in reactivity to the environment" (p. 88). Catatonia is often associated with *mutism* and *stupor* (lacking speech and movement) but can also present as *negativism* (failing to follow instructions), as well as holding rigid poses for long periods of time, grimacing, or staring (APA, p. 88). The last key feature presented in the DSM-V are *negative symptoms.* Negative symptoms refer to a *lack* of normal psychological function, and most often include "diminished emotional expression," *avolition* (a lack of motivation), *alogia* (lack of speech), *anhedonia* (lack of feeling pleasure) and *asociality* (a lack of desire for social interaction) (APA, p. 88). It is important to note that psychosis is a complex phenomenon associated with a variety of different diagnoses. While psychosis is a defining feature of a variety of psychotic disorders, it may also be a symptom of a mood disorder, such as depression or bipolar disorder, a brain injury, epilepsy, or substance use, among others (APA, 2013; Devinsky, 2008). After summarizing these 5 key features, the DSM-V goes on to outline several diagnosable conditions (APA, 2013). These include delusional disorder, brief psychotic disorder, schizophrenia, and schizoaffective disorder, among others. The DSM-V stipulates they can all be defined by symptoms in the aforementioned five key domains.

Aetiology and Prognosis. While perspectives on the aetiological underpinnings of psychosis have shifted greatly over the past several centuries, modern medicine has yet to fully understand all aspects of both the aetiology and prognosis of psychotic disorders. As mentioned previously, psychosis is a symptom of a variety of different conditions, and it would be too vast a task to attempt to summarize the aetiology and prognosis of every condition. Provided here is a brief overview of current perspectives on the aetiology and prognosis of schizophrenia, bipolar

and related disorders, and substance/medication-induced psychotic disorder, specifically cannabis-induced psychosis.

Schizophrenia. According to the DSM-V, there are a variety of factors that contribute to the development of schizophrenia, however, “the predictors of course and outcome are largely unexplained” (APA, 2013, p. 102). Research demonstrates that various environmental factors are associated with increased risk of schizophrenia, including season of birth[8], birth complications with hypoxia[9], greater paternal age, and growing up in an “urban environment” (APA, p. 103). According to the DSM-V, “other prenatal and perinatal adversities, including stress, infection, malnutrition, maternal diabetes, and other medical conditions, have been linked with schizophrenia,” however, most individuals with these risk factors do not develop schizophrenia (APA, p. 103). More recent research has also begun to focus on the link between ACEs (adverse childhood events) and the development of schizophrenia, generally finding a positive association between the two (Robinson & Bergen, 2021). Regarding pathophysiology, there are several hypotheses regarding the development of schizophrenia. The “neurochemical abnormality hypothesis” posits that an imbalance of neurotransmitters is responsible for the manifestation of symptoms (Hany et al., 2023, para. 8). The “disconnect hypothesis” focuses on the anatomical, neurological differences in those with schizophrenia, including a reduction in grey matter in the

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[8] The exact mechanisms underlying the “season on birth effect” are unknown at this time, however potential hypothesis include an increased risk for viral infections during these months, and an increased risk of vitamin D deficiency, both of which may be associated with an increased risk of schizophrenia (Escott-Price, 2019, p. 2499).

[9] "A state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis” (Bhutta, Alghoula, & Berim, 2022, para. 3).

temporal[10] and parietal lobes (Hany et al., para. 10). Lastly, some researchers argue schizophrenia is a “neurodevelopment disorder” based on “abnormalities present in the cerebral structure” and the fact that certain motor and cognitive impairments precede the onset of symptoms (Hany et al., para. 9). The "psychotic features” of schizophrenia generally emerge between the “late teens and the mid-30s; onset prior to adolescence is rare” (APA, p. 102). Most individuals present with a “slow and gradual development” of various signs and symptoms, with half of them experiencing “depressive symptoms” (APA, p. 102).

Bipolar and Related Disorders. Bipolar and related disorders include bipolar I, bipolar II, and cyclothymic disorder. The DSM-V places bipolar and related disorders between the chapters on “schizophrenia spectrum and other psychotic disorders” and “depressive disorders” in order to acknowledge “a bridge between the two diagnostic classes in terms of symptomatology, family history, and genetics” (APA, 2013, p. 123). Bipolar and related disorders are characterized by episodes of depression mixed with episodes of mania (APA). According to Canadian Association of Mental Health (CAMH) (2019), approximately 50 to 95 percent of individuals with bipolar disorder will experience psychotic symptoms, including paranoid or grandiose delusions, disorganized thought and speech, and hallucinations (APA, 2013; [CAMH], 2019). Like many psychiatric conditions, the exact cause of bipolar is unknown (National Institute of Mental Health [NIMH], 2022). Several environmental factors are thought to influence the development of bipolar disorder, including marital status (separated, divorced, or widowed individuals are more likely to be diagnosed than married individuals), childhood trauma, and substance use

[10] As discussed previously, due to the fact that R-S experience is closely linked to the temporal lobes, abnormal activity in the temporal lobes may provide an explanation for both R-S experience *and* psychosis (Ng, 2007).

(APA 2013; Robinson & Bergen, 2021). It is genetic factors however that appear to have a more significant influence, with individuals who have a relative with bipolar disorder facing a 10-fold increased risk of developing the disorder themselves (APA). Lastly, research demonstrates that "brain structure and function of people with bipolar disorder may differ from those of people who do not have bipolar disorder," implying that physiological abnormalities may also play a role in development (NIMH, 2022, para. 15). The mean onset of symptoms related to bipolar disorder is 18 years of age, but can occur "throughout the life cycle," including into ones 60's or 70's (APA, 2013, p. 130). According to the DSM-V, the presence of psychosis can impact prognosis, increasing the risk of future psychotic episodes, and decreasing the likelihood of "inter-episode recovery" (APA, p. 130).

Substance/Medication-Induced Psychotic Disorder. In discussing substance/medication-induced psychotic disorders, the specific focus will be on cannabis-induced psychosis. The reason for this is two-fold: First, Canada has one of the highest rates of cannabis use in the world, with 50% of young adults aged 20-24 reporting use, and 37% of 16–19-year-olds reporting use (Kourgiantakis et al., 2023), virtually guaranteeing that mental health practitioners working in Canada will provide services to individuals who use cannabis. Secondly, there is an extremely well-established connection between cannabis use and psychosis. The DSM-V defines *Substance/Medication-Induced Psychotic Disorder* as the presence of delusions and/or hallucinations whereby there is sufficient evidence that the symptoms "developed during or soon after substance intoxication or withdrawal or after exposure to a medication," and that, once the effects of the substance wear off, the symptoms of psychosis will resolve (APA, 2013, p. 110). It is important to note that cannabis can induce transient (i.e., temporary) episodes of psychosis, but

may also contribute to the development of schizophrenia or other psychotic disorders (Hasan et al., 2020). While the exact link between cannabis and psychosis is unclear, research indicates it may involve “dopamine, GABA, and glutamate neurotransmission,” and is related to quantity, “duration of exposure,” and the age of initial exposure (Shrivastava et al., 2014, p. 13). Furthermore, of the vast number of cannabinoids[11] found in cannabis, delta-9-tetrahydrocannabinol (TCH) is thought to be “main psychoactive molecule” responsible for symptoms of psychosis (Hasan et al., 2020, p. 403). While a plethora of research has explored the connection between cannabis and psychosis, there is no clear-cut *causal* pathway between the two, however, the fact that there is a relationship is clear. Hasan et al. (2020) provided an extensive review of various pre-existing meta-analyses of the existing literature on cannabis use and psychosis. They concluded that: “(1) psychotic illnesses occur more frequently in cannabis users than non-users, (2) that any lifetime cannabis use is associated with a 1.4 and cannabis dependence with a 3.4-fold increased risk of developing psychotic illness, and (3) that cannabis users have an earlier onset of psychoses than non-users” (p. 409). Cannabis arguably plays a pertinent role in the aetiology and prognosis of psychosis, especially in a Canadian context.

Current Treatment

Presently, antipsychotic medication is considered the “mainstay of treatment” along with psychosocial rehabilitation, counselling, and family education (Tsuda et al., 2022, p. 21). The following discussion on psychosis treatment will be structured into three sections: pharmaceutical interventions, inpatient treatment (i.e., hospitalization), and psychosocial treatment.

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[11] The active, biological compounds found in cannabis plants, which bind to cannabinoid receptors in the brain (Sheik & Dua, 2023).

Pharmaceutical Interventions. As mentioned previously, antipsychotic medication is thought to be a highly pertinent component in the treatment of psychosis. According to Early *psychosis: An information guide* published by the Canadian Association of Mental Health (CAMH), antipsychotic medication is generally divided into *typical* or first generational antipsychotics, and the newer *atypical* or second generation antipsychotics (Tsuda et al., 2022). Typical antipsychotics, such as Haldol, Loxapac, and Fluanxol, were developed in the 1950s, whereas atypical antipsychotics, like Seroquel, Abilify and Risperidone hit the market in the 1990s (Maddux & Winstead, 2019; Tsuda et al., 2022). Like most psychiatric medication, the exact mechanism by which antipsychotic medication works is unknown, but all antipsychotics are thought to work by reducing the availability of dopamine in the brain (Maddux & Winstead). Being that antipsychotic medication has been around for 70+ years, there is a vast amount of literature regarding their effectiveness, and today "there is overwhelming evidence that antipsychotic drugs […] are effective in preventing relapse and symptoms" (Wunderink, 2019, p. 11). There is a general belief among mental health practitioners that *maintenance treatment,* or continuing to take antipsychotics after acute symptoms have dissipated, is generally necessary (Patel 2014; Wunderink, 2019). Some researchers however argue that such adherence is not necessary, and that a certain percentage of patients are better off discontinuing antipsychotics altogether (Volavka & Vevera, 2018). Antipsychotics are associated with a vast number of potentially serious side effects, including movement-related side effects, such as severe restlessness, muscle stiffness, tremors, and tardive dyskinesia[12] (TD), metabolic side effects,

[12] TD is characterized by "involuntary, spontaneous movements of the face and body" (Tsuda et al., 2022, p. 25). For every year that an individual is taking an typical antipsychotic medication, the risk of developing TD increases by 5%, thus, after 5 years, the risk of developing TD would be 25% (Tsuda et al.).

including elevated blood glucose and lipids, and hormonal side effects including sexual dysfunction, changes in menstrual cycle, and abnormal production of breast milk (Tsuda et al., 2022). Other side-effects include dry-mouth or sialorrhea[13], constipation, blurred vision, abnormalities in heart rhythm, sedation, and neuroleptic malignant syndrome, a potentially deadly syndrome characterized by fever, agitation, and altered mental status (Stroup & Gray, 2018; Tsuda et al., 2022). Such debilitating side-effects inevitably play a role in anti-psychotic adherence rates, which are arguably poor. A recent study by Lieslehto et al. (2022) found that approximately 31.7% of individuals with a diagnosis of schizophrenia failed to even fill the prescription for their antipsychotic medication within a year of it being prescribed, and previous research has found that only 40-60% of individuals with a diagnosis of schizophrenia take their medication as prescribed (Cramer & Rosenheck, 1998, as cited in Lieslehto et al., 2022). According to a review by Wunderink (2019), which aimed to examine the necessity of continuing to take antipsychotics, approximately 35% of patients with first-episode psychosis do *not* need to continue maintenance treatment: "in these patients, after the adequate treatment of the episode to remission, the antipsychotics can be gradually tapered without recurrent symptoms or relapse" (p. 11). The issue is, there is no way to tell *which* patients can safely taper off, and which are likely to relapse, and preventing relapse is arguably a high priority in promoting recovery. Relapse has generally been considered "one of the most important predictors of worse outcome in psychosis" (Wunderink, 2019. p. 8). Not only does a relapse entail a return of acute psychotic symptoms and potential hospitalization, but it increases the risk of "treatment resistance," i.e., an inability to recover from a psychotic episode (Wunderink, p. 8). According to

[13] Excess production of saliva (Stroup & Gray, 2018).

Wunderink, no relapses in a 7-year follow-up period was associated with a recovery rate of about 50%, whereas 3 or more relapses lead to "no recovery at all," leading Wunderink to conclude that maintenance antipsychotics play an important role in postponing potential relapse (p. 8). Like many medications, antipsychotics do come with a host of potential risks, however, they are generally effective in alleviating symptoms of psychosis, and are thus an appropriate treatment option for many individuals.

Inpatient Treatment. Inpatient hospitalizations for psychiatric conditions are intended for individuals during periods of acute distress and risk (Fenton et al., 2014). In the western world, it is not uncommon for individuals experiencing psychosis to be hospitalized, especially during first-episode psychosis, i.e., the first time they experience psychotic symptoms (Rodrigues et al., 2019). According to the WHO (World Health Organization) (2022) 50% of patients in psychiatric hospitals have a diagnosis of schizophrenia. In Canada, psychotic disorders were the third highest reason for inpatient hospitalization in 2019-2020: "Over 37,000 Canadians account for 2.5% of in person hospitalizations with an average acute [length of stay] of 19.6 days" (Canadian Institute for Health Information (CIHI), 2021, para. 12). Furthermore, individuals who are diagnosed with psychotic disorders are "more likely to have non-psychiatric hospitalizations than the general population" (Weissinger et al., 2021, p. 306). It is worth noting that the bulk of psychiatric inpatient hospitalizations in Canada are involuntary, meaning the patient is unable to leave even if they would like to. A study published by Lebenbaum et al., in 2018, found a "high and increasing prevalence of involuntary admissions" in Ontario, with 70.7% in 2009, and 77.1% in 2013 being involuntary psychiatric admissions (p. 31). A study conducted by Rodrigues et al., in 2019 found that 81% of the admissions for people aged 16 to

35 with first-episode psychosis in Ontario were involuntary, and that one quarter of young people with first-episode psychosis will have an involuntary hospital admission early in the course of their illness. Even though inpatient hospitalization for psychosis is a common practice, there is a “lack of clarity regarding the purpose and function of psychiatric hospital care” (Wood et al., 2019, p. 1), with the WHO (2022) arguing that “there is clear evidence that mental hospitals are not effective in providing the care that people with mental health conditions need” (para.22). Finding clear guidelines for inpatient hospitalization for psychosis proved vastly difficult. According to an article by Feifel (2000) titled *Rationale and Guidelines for the Inpatient Treatment of Acute Psychosis,* the “preeminent therapeutic goal” is to rapidly stabilize acute positive symptoms, hostility, and agitation through the use of antipsychotic medication (p. 27). A qualitative study conducted by Wood et al., (2019) aimed to explore both patient and staff perspectives on inpatient hospitalization for psychosis. According to their study, psychiatric staff provided a variety of priorities within their inpatient unit, including continual observation of patients, risk reduction and management, family involvement, and planning for ongoing care in the community (Wood et al.). Staff also described a variety of barriers to providing quality treatment, including a lack of resources, a confined environment, and a lack of safety (Wood et al.). Themes which emerged for patients included feeling there was lack of collaboration in care, poor relationships with staff, and unclear, rigid treatment protocols: “many participants experienced their admission as traumatic and disorientating, especially those who were forcibly detained” (Wood et al., p. 3). The findings of Wood et al., are by no means uncommon: The literature generally describes inpatient treatment for those with psychosis as traumatic, frightening, and chaotic (Fenton et al., 2014; Rodrigues & Anderson, 2017; Tidefors & Olin,

2011). While inpatient hospitalization may prove necessary for a minority of individuals at risk of harming themselves or others, the purpose and efficacy of inpatient treatment for psychosis remains unclear.

Psychosocial Treatment. There is significant evidence that psychosocial interventions can be effective in supporting those with psychosis (Lecomte et al., 2014). Mainstream treatment protocols generally recommend a combination of both medication and psychosocial treatments, emphasizing the importance of early intervention (National Institute of Mental Health [NIMH], 2023). A vast systemic review and meta-analysis conducted by Frawley et al. (2023) reported that psychosocial interventions are associated with “significant improvements in social and occupational function” in those experiencing psychosis. Evidence-based interventions include dialectical behavioural therapy (DBT) (Mullen, 2021), acceptance-commitment therapy (ACT) (Davies et al., 2019), cognitive behavioural therapy for psychosis (CBT-p) (Lecomte et al., 2014; Sivec et al., 2017), cognitive remediation training (CRT), family-based interventions, and supported employment training (Frawley et al., 2023; Lecomte et al., 2014). According to Frawley et al.’s review, one important component when analyzing the effectiveness of psychosocial treatments is the *context* in which the treatment is delivered. Their findings indicate that delivering interventions in community, as opposed to “clinic-based settings,” had a significant effect on efficacy and that service providers should aim to offer services in an individual’s “usual environment,” while working to include “key community stakeholders,” i.e., family, friends, and other community support persons (p. 1795- 1796). This would explain why a family-based intervention provided in the community may be *more* effective than individual CBT-p provided in a clinical setting (Frawley et al.). Regardless, psychosocial interventions are a

highly important piece in the treatment, and yet, they remain under-utilized. According to Lecomte et al. (2014), even though there is significant evidence to support the utilization of psychosocial interventions, the literature reveals that “few, if any, are ever implemented in a given setting” (p. 438). One possible barrier may be perceived cost of community services; research indicates, however, that providing outpatient interventions to individuals experiencing psychosis actually reduces the need for inpatient hospitalization and reduces overall cost of treatment (Swanson et al., 2013). Lecomte et al. (2014) provide several possible solutions for the lack of implementation, including large scale solutions such as reforms, and “demonstration projects and effectiveness trials,” as well as smaller scale solutions, such as offering clinical training to staff from various backgrounds, such as nurses or social workers (Lecomte et al., p. 439). Despite the fact they may not always be properly implemented, the literature suggests that psychosocial, community-based interventions remain a key component in the recovery of those experiencing psychosis.

A Non- Western Perspective

It is important to remember that many cultures possess very different understandings of what the West classifies as “psychosis,” and that it is highly likely that in providing services to individuals experiencing psychosis, mental health practitioners will encounter a wide variety of cultural understandings about both psychosis, and R-S experiences. While the term “non-Western” encapsulates a wide variety of different perspectives, the focus here will be on the connection between psychosis and *shamanism*. This link has long been discussed in various disciplines: “One of the oldest questions in anthropology,” says Luhrmann et al. (2023), "is whether “our” schizophrenia is “their” shamanism, whether someone diagnosed with

schizophrenia in the modern west might become a shaman in some other society and so avoid the stigma and disability we associate with the condition today" (p. 2) "Shamanism" is a complex term with a variety of definitions: In his book *An Introduction to Shamanism*, DuBois (2009) defines shamanism as "a set of practices and understandings concerning the cosmos, spirits, and human needs" (p. 6). "The shaman" says DuBois "enter[s] into trance states through communally recognized rituals" and "cultivates personal relations with helping spirits in order to achieve particular ends for the community: generally, healing, divination, and/or the control of fortune" (p. 6). Shamanism has been labeled "the world's oldest form of religion" (Vitebsky, 2000, as cited in DuBois, 2009), and it continues to be practiced by a vast number of traditional cultures in countries across the world (Eliade & Diószegi, 2024). Furthermore, many New Age practices have adopted aspects of shamanism, referred to as "neoshamanism" (Scuro & Rod, 2015). Phil Borges, a photographer, and film maker has spent the majority of his career travelling and documenting the experiences of Shamans in traditional cultures, including peoples in Ecuador, Mongolia, Siberia, Pakistan, Afghanistan, Kenya, and Tibet, among others (TEDx Talks, 2014). While Borges recognizes that not all the experiences of shamans are homogenous, he describes many common themes across the experiences of individuals who adopt Shaman-like roles within their communities. "They typically are identified with what they called the 'call'," says Borges, "and the 'call,' [for] the ones I interviewed, almost all of them, it was a psychological crisis. Secondly, they almost always had a mentor. Somebody that has been through it and has come out the other end of this psychological crisis and can show them the ropes" (TEDx Talks, 13.05). This "psychological crisis" that Borges describes often involves aspects of what the West would call "psychosis", including hearing voices, having visions, and experiencing somatic symptoms

such as dizziness. For example, when Borges asked the Oracle of Tibet, (i.e., the Oracle to the Dalai Lama) about his experience stepping into his role, he stated: "When I was younger, I had started hearing these voices. I started feeling very ill, and I was very confused, and in fact, I thought I was dying at one point. An older monk came to me and said, 'Hey, you've got a gift.' He taught me how to go in and out of trance" (TEDx Talks, 5.23). While it would be a naive oversimplification to conclude that *all* individuals who experience "psychosis" in the Western world would inevitably become successful Shamans had they been born into a different culture, it's very possible that a percentage of them would. In Phil Borges' (2014) film *Crazywise,* physician and author Gabor Mate argues the following:

> According to the research, the best place to be a schizophrenic, in the world, is not North America, with all its pharmacopeia. It's actually a village in Africa or India, where there's acceptance, where people make room for your differentness, where connection is not broken but is maintained, where you're not excluded and ostracized but where you're welcomed […] where the whole community might even sing with you or chant with you or hold ceremony with you and maybe find some meaning in your quote-unquote craziness. It's contextual and its cultural (0.45)

Such emphasis on the value of community is completely in line with the aforementioned research by Frawley et al. (2023) which firmly established the importance of community and family when delivering psychosocial interventions. It is not terribly difficult to imagine how an individual experiencing psychosis may, at times, fare better in a collectivist or tribal community, versus a Western medicalized setting, which firmly upholds psychosis as a meaningless disease. It was American author Andrew Solomon who wrote in his best-selling book *Far From the Tree:*

Parents, Children, and the Search for Identity "the remarkable parents I met during this research would be better off, as would their children, if schizophrenia didn't exist. To me, their suffering seemed unending, and singularly fruitless" (2012, as cited in Wilensky-Lanford, 2012). While such a brash statement may ring true for some families and individuals living with psychosis, it stands in stark contrast to many of the experiences of the individuals interviewed by Borges (2014). Acknowledging that the "Shaman" phenomenon merely *exists* in other cultural contexts, and is defined, not as an illness, but as a beneficial service to the community, forces us to be critical of the Western paradigm that posits psychosis as an illness to be cured, and nothing more.

R-S Themes in Psychosis

Prevalence. According to Rosmarin (2018) current estimates indicate up to 22% of patients diagnosed with bipolar disorder, and 39% of patients diagnosed with schizophrenia experience R- S delusions, "making these symptoms among the most common in inpatient settings" (p. 52). A review conducted by Grover et al. (2014) argues the prevalence of R-S themes in individuals experiencing psychosis varies from country to country. A study conducted in Lithuania for example, which surveyed a sample of 295 individuals who met the criteria for schizophrenia, reported that approximately 63.3% of participants experienced "religious delusions" (p. 529). Another review conducted by Cook (2015), which attempted to summarize decades of research on R-S delusions, reported "studies of RD [religious delusions] have found between 1.1% and 80% of deluded subjects to report at least some religious content in their delusions. More typically, figures between 20% and 60% are reported" (p. 415). Cook argues that such a high variability is likely due to a lack of proper definition of "what counted as religious content" (p. 415). For example, "themes related to magic, death, spirit possession,

witchcraft, the supernatural and so on were sometimes included and sometimes not included" (Cook, p. 415). Thus, it is highly likely that studies which only focused solely on "religious" content from recognized faith traditions, were much likely to report a lower rate of religious content, as their scope was much narrower. Furthermore, one's R-S, or cultural, background may also alter the frequency of R-S symptoms. For example, according to Grover et al. (2014), studies have demonstrated that Buddhists generally have a lower frequency of R-S delusions than Christians, and that those from protestant backgrounds are more likely to experience more R-S delusions than Catholics, or individuals with no religious affiliations. Regardless, a fair percentage of individuals experiencing psychosis *will* experience R-S themes, making this a relatively prevalent phenomenon.

Content. Having already discussed how psychosis commonly presents, it is not difficult to imagine how R-S themes may show up for individuals experiencing hallucinations and/or delusions. According to the review by Grover et al. (2014), R-S hallucinations and delusions often relate to themes such as "prayer, sin, possession […] spirits, demons, being bewitched, mythical forces, ghosts, sorcery, [or] voodoo," as well as specific R-S figures such as Jesus, the Devil, or the Prophet Muhammed (p. 120). A series of case studies conducted by Murphy (2000) which explored qualitative accounts of eight individuals with psychosis found that all accounts included R-S themes, specifically "demonic attack" (p. 182): "When Janet first became ill she heard six different voices. One said it was going to kill her. Another told her to kill the mayor […] she knew about Satan and believed they came from him […] she thought she was lost to Satan (Murphy, p. 179). The individuals in Murphy's sample generally experienced frightening themes: "positive themes […] occurred infrequently. When hallucinations involved beautiful,

encouraging or supportive content, some found these to have real meaning and considered them to be divine in nature. Still, others believed them to be deceptions on the part of the devil" (p. 181). Another common presentation of R-S symptomology is grandiosity (American Psychiatric Association [APA], 2013; Grover et al., 2014). In fact, R-S grandiosity is so commonplace that the phenomenon inspired the colloquial term *messiah complex*, described in earlier literature as a delusion in which the individual "come[s] to consider himself as a specially ordained pillar of God, the messianic centre around which all world phenomena are organized" (Goldwert, 1993, p. 331). According to Fretheim[14] (2015), grandiose delusions are often religious or spiritual in nature, causing an individual to believe they are a R-S figure, such as Jesus Christ, or another "messenger from God" (p. 15). Of course, one's cultural and/or R-S background will influence the content of said delusions. While Fretheim describes working with various patients who believed they were Jesus Christ, individuals from non-Christian backgrounds often present with delusions inline with their own traditions, such as a Jewish client who "imagined himself with incredible knowledge that he had gained from reading Genesis 1–3" (Clark, 1980, as cited in Fretheim, 2015). A study by Suhail and Gauri (2010) which examined the delusional content of Pakistani Muslims, found that individuals in their sample identified with figures such as Allah or the Prophet Muhammed, and professed supernatural powers such as the ability to control lightening, wind, rain, and Jinn[15]. While there are many similarities in the content of R-S themes in psychosis, these are inevitably influenced by one's R-S, and cultural background.

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[14] Fretheim worked as a spiritual care practitioner at the Forensic Psychiatric Hospital located just outside of Vancouver, in Coquitlam, BC (Fretheim, 2015).

[15] "Supernatural creatures in Islamic mythology, capable of good or evil. They can act upon or be acted upon by humans" (Fretheim, 2015).

Prognosis. According to the literature, R-S symptomology, belief, and practice in those experiencing psychosis can play a significant role in prognosis and treatment outcomes. It is important to note that this relationship is complex and seemingly paradoxical: The presence of R-S themes in psychosis is correlated with poorer outcomes, and yet engaging with R-S beliefs and practices is associated with *better* outcomes (Grover et al., 2014; Rosmarin, 2018). The literature suggests that R-S delusions are held with "more conviction and pervasiveness than other delusions” (Grover et al., 2014, p. 120). Individuals with R-S delusions may take longer to seek treatment, are prescribed more medication, have “overall higher symptom scores” and “poorer functioning” (Grover et al., p. 121). Furthermore, individuals with psychosis with R-S themes are more likely to receive “magico-religious healing,” and are less satisfied with psychiatric treatment, thus leading to poorer adherence (Grover et al.). While this relationship is not necessarily *causal*, the link between R-S symptomology, and poor treatment outcomes has been firmly established. Rosmarin (2018) argues that while factors such as a “refusal to comply with treatment” due to R-S beliefs may contribute to this phenomenon, a “more important factor,” is that treatment remain
“culturally and spiritually sensitive” (p. 55-56). As will be discussed in more detail later on, research indicates that individuals presenting with R-S concerns, especially those from cultural or R-S minorities, face more barriers in accessing both adequate assessment and treatment from mental health practitioners (Adenpole et al., 2012; Ayvaci, 2017; Huguelet et al., 2006). This disparity in care inevitably contributes to poorer treatment outcomes for individuals with R-S symptomology, especially in regard to treatment adherence. Despite this, the literatures suggests that R-S engagement can produce *better* outcomes for individuals experiencing psychosis.

According to Huguelet and Mohr (2009, as cited in Roystonn et al., 2021) individuals living with psychosis often attribute "great importance" to spirituality or religion and report heavy engagement in personal or communal R-S practices (p. 1). A study by Borras et al., (2010) which aimed to measure spirituality and religiosity among 121 patients living with psychosis found that patients could be characterized "by a high level of spirituality" (p. 82). Research conducted by Mohr et al., (2006) which examined a sample of 115 patients diagnosed with a psychotic disorder, found that 85% of the sample stated religion was "important," in their lives: "For nearly half the patients (45%), religion was the most important element in their lives; 78% rated it as being important to essential in day-to-day life, 67% in giving meaning to their lives, 59% in giving meaning to their illness" (p. 1953). It is important to highlight that pre-existing R-S beliefs or practices do *not* increase the risk of developing R-S symptomology: "there is no evidence," argues Rosmarin (2018), "to suggest that an [R-S] belief or practice is associated with a greater prevalence of or severity in psychotic disorders" (p. 50). Furthermore, according to Grover et al., (2014), the literature shows that religiosity in individuals with schizophrenia is linked with "increased social integration," reduced risk of suicide attempts and substance use, decreased rates of tobacco use, a higher quality of life, and overall better prognoses (p. 121). Often, the opportunity to engage with one's R-S beliefs and practices can produce significant benefit for those experiencing psychosis. According to Murphy (2000), for several of the participants in her study, it was "their faith in God" that prevented them from attempting suicide (p. 182). "Just as the 'evil forces' of psychosis had destructive consequences," says Murphy, "good forces of religious beliefs […] also had their consequences" (p. 182). Murphy concluded that the ability to engage with one's R-S beliefs and practices "empowered" individuals to take

positive steps towards recovery: “The resulting improvement in the participant’s mental condition was often substantial and worthy of consideration” (p. 182). Even though individuals with R-S psychosis may present with additional difficulties when it comes to treatment adherence, the literature makes it very clear that engagement with one’s R-S beliefs, practices, and community can be an extremely pertinent factor in the recovery of those experiencing psychosis.

R-S Incompetency

As was alluded to in the previous section, discrepancies in care for those presenting with R-S concerns can lead to poor treatment adherence, and overall poorer prognosis. Unfortunately, the literature indicates that these discrepancies are rampant in the Western mental health system. According to the Equal Employment Opportunity Commission (2017, as cited in Vang et al., 2019) religious discrimination refers to the "unequal treatment of individuals and/or groups based on religious beliefs” (p. 1914). According toVang et al. (2019) due to both immigration, and conversions, Canada has seen an increase in “religious minorities,” including Hindus, Sikhs, and Buddhists (p. 1914). They argue that due to “visible differentiation” in terms of both faith and ethnicity, R-S minorities are more likely to experience discrimination, and therefore, decreased quality of life (p. 1914). As was discussed previously, more than two thirds of mental health practitioners report “little-to-no clinical training” in religion or spirituality, and one quarter feel significant discomfort when discussing R-S beliefs with clients (Rosmarin et al., 2013, p. 430). Psychiatrists specifically are generally less religious than other medical practitioners, and in the West, patients generally report “difficulty finding a psychiatrist with an understanding of their religious beliefs” (Ayvaci, 2017, p. 12). According to Ayvaci, evidence suggests

psychiatrists may struggle with "separating normal and pathological expressions of religiosity" (p. 12). A study conducted by Huguelet et al. (2006), which analyzed a sample of 100 patients with a diagnosis of schizophrenia, found that only 36% of the sample had discussed religion with their psychiatrist, despite the fact the majority of patients felt religion was an "important aspect of their lives" (p. 366). "In half the cases," says Huguelet et al. "[the psychiatrist's] perceptions of patients' religious involvement were inaccurate" (p. 366). A study by Borras et al. (2007) which examined the relationship between religiosity and treatment adherence in individuals diagnosed with schizophrenia concluded that mental health practitioners underestimate the importance of R-S beliefs, citing a "lack of knowledge of religions," and a "tendency to pathologize many thoughts and behaviors in reference to spirituality among patients" (p. 1243). This knowledge gap not only contributes to poorer outcomes for patients, but it also actually impacts the ability of mental health practitioners to provide accurate assessment and diagnoses. A study by O'Connor and Vandenberg (2005), which examined the attitudes of mental health practitioners towards patient's of different faith backgrounds in the United States, found that clinicians were more likely to rate R-S beliefs held by Muslim clients as "highly pathognomonic," compared to the R-S beliefs of Christian clients (p. 615). A study by Adenpole et al. published in 2012, examined a sample of patients from "ethnic minority and immigrant backgrounds" accessing psychiatric services in Montreal, Quebec, over a 10-year span (p. 147). They found the patients in the sample were frequently *misdiagnosed* with psychosis: "for 70 patients [...] use of the DSM-IV cultural formulation for case reassessment resulted in 34 (49%) patients' illnesses being rediagnosed as nonpsychotic disorders" (Adeponle et al., 2012, p. 151). This means almost *half* of the patients from minority backgrounds diagnosed with psychosis

were *misdiagnosed*. Adenponle et al., argue such misdiagnoses are likely the result of clinicians mistaking "culturally normative behaviour" as pathological, and failing to "elicit crucial diagnostic information or misinterpret it because of insufficient attention to social, cultural, and contextual factors" (p. 147). The DSM-V heeds a wide variety of warnings regarding R-S practices and potential misdiagnoses, noting that various symptoms of psychosis may be a normal part of one's cultural or religious background, and therefore cannot be apathologized:

> Cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and socioeconomic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content (e.g., hearing God's voice) are a normal part of religious experience (APA, 2013, p. 103)

Despite the efforts of the DSM-V to consider R-S factors, the literature provides significant evidence that mental health practitioners are lacking the knowledge and understanding necessary to adequately assess individuals presenting with R-S symptomology. R-S incompetency on behalf of practitioners not only leads to dissatisfaction with treatment, but inaccurate assessment, and poorer treatment outcomes.

R-S Competency and How Mental Health Practitioners Can Best Serve Those with Psychosis with R-S Themes

As previously discussed, the literature indicates that mental health practitioners are often highly interested in gaining R-S competency (Rosmarin, 2013). According to Bono et al. (2011), mental health practitioners display higher overall job satisfaction when they feel competent in working with the specific population they are serving and display high levels of motivation to

attain this competency. Unfortunately, mental health practitioners often struggle to find time to come together for training while trying to balance a demanding, and often chaotic, workplace environment (Bono et al.). The following sections aim to provide simple and practical guidance for mental health practitioners to cultivate R-S competency in both assessment and treatment planning.

R-S Competency in Assessment

Due to the relationship between R-S beliefs, practices and prognosis, it is highly important that mental health practitioners understand *how* to assess R-S presentations. In his book titled *Spirituality, Religion, and Cognitive- Behavioral Therapy: A Guide for Clinicians*, Rosmarin (2018) provides a general template for assessing the R-S beliefs and practices of his clients. This includes gaining basic information about a client's R-S beliefs and practices, understanding how these beliefs and practices relate to an individual's symptoms, and inquiring whether the individual would like to further explore their R-S beliefs and practices in treatment. While this template serves as an excellent starting place, assessing the R-S beliefs and practices of individuals who may be experiencing R-S psychosis undoubtedly presents added challenges. The following section will discuss steps mental health practitioners can take to a) better differentiate between R-S symptoms, and R-S beliefs and practices associated with bona fide faith traditions, and b) discern which R-S beliefs and practices are benefitting an individual's recovery, and which may be harbouring it.

R-S Symptoms Versus Bona Fide Belief and Practice. According to Rosmarin (2018) it is necessary for mental health practitioners to work to differentiate between R-S symptomology, and bona fide R-S beliefs and practices (p. 56). Unfortunately, there are no clear clinical

guidelines to distinguish between true, or “normal” R-S beliefs, and “pathological" R-S delusions, making this a seemingly daunting task for many practitioners (Pierre, 2001, p. 163). “[R-S] symptoms can closely resemble bona fide [religion and spirituality] says Rosmarin, “[R-S] life is often replete with cultural nuances, and making accurate distinctions between culturally normative beliefs and practices on the one hand and spiritual symptoms on the other can be challenging” (p. 56- 57). Rosmarin (2018) suggests starting with an open conversation with individuals regarding their R-S beliefs and practices, in an effort to understand the individual’s *own* insight. (p. 57). Of course, in many cases, individuals with psychosis may lack the insight to be able to successfully differentiate between the aspects of their R-S beliefs which are part of their illness, and those which are not. “In such cases” says Rosmarin (2018) “reading up on patients’ traditional religious standards […] may be clinically beneficial” (p. 58). As Rosmarin stipulates, it is not necessary for practitioners to maintain an in-depth knowledge of world religions, however, taking some time to understand the basic principles, practices and beliefs of various faith traditions can go a long way (p. 57). There are a vast number of free and accessible resources which mental health practitioners can access to gain this information. For example, *Spiritual Care A multi-faith resource for healthcare staff* [16]published by the NHS Education for Scotland (NES) (2021), provides a brief overview of various faith traditions, as well as pertinent points for healthcare workers to consider when working with this population. There are also more comprehensive resources that have been created to support practitioners in working with patients of specific faith backgrounds, such as *Providing Diversity Competent Care to Muslims:*

[16] See https://www.nes.scot.nhs.uk/media/ay4je0io/multi-faith-resource-for-healthcare-staff.pdf

A handbook for health care providers published by Fraser Health Authority (2014)[17] or *Sikhism: A Healthcare Worker's Guide*[18], published by The Sikh Coalition (2021). Alongside accessing written resources, mental health practitioners may also benefit from consulting with R-S experts in their network. In Canada, *spiritual care practitioners* are registered, masters level practitioners who often work within various settings, including health care, military and corrections, providing holistic support to individuals with a focus on spirituality, religion, and culture (Canadian Association for Spiritual Care [CASC], n.d). In BC, spiritual care practitioners work in healthcare settings across the province (CBC News, 2023): For example, according to both Vancouver Coastal Health (2024) and Fraser Health (2024), spiritual care services are available within any health authority facility, including hospitals, residential settings, and community settings, to patients, family, and staff. When available, spiritual health practitioners can provide the support and knowledge necessary to assist mental health practitioners in accurately assessing an individual's R-S beliefs and practices. Another option is for mental health practitioners to connect directly with a R-S leader within a specific faith community. "Proactive collaboration with clergy" says Rosmarin (2018) "is often clinically indicated to help patients and clinicians alike to distinguish between bona fide religious rites and psychopathological rituals that feign legitimate foundations" (p. 51). There are cases wherein an individual may be engaging with spiritual practices and beliefs which are not associated with any established faith tradition, such as new age or shamanic practice. In this case, it may be more appropriate to collaborate with an

[17] See https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/Professionals-Resources/Diversity-Services/201609ProvidingDiverseCaretoMuslimClients.pdf?rev=ca670de6a55c4e79b59704db0ea6e217

[18] See https://www.sikhcoalition.org/resources/sikhism-healthcare-guide/

individual's family or other community members to try and establish what is normal for that individual. Unfortunately, there is no exact template to apply when assessing an individual's R-S beliefs and practices. Rosmarin (2018) suggests a handful of concrete pathological presentations, including "reciting bizarre prayers that are not part of any faith" and "belief that one can hear God speak," but even these could potentially be normal presentations in some traditions (p. 56). While adequate assessment may be challenging, working collaboratively with clients, gaining knowledge, and consulting with R-S experts are all steps mental health practitioners can take to accurately assess individuals presenting with potentially pathological R-S beliefs.

Harmful Versus Helpful R-S Coping. While differentiating between R-S symptomology and bona fide R-S belief and practice is critical, understanding *how* R-S beliefs and practices are impacting an individual's quality of life is arguably even more important. One way mental health practitioners may be able to do this is by examining R-S *coping* in clients. In *The Handbook of Religion and Mental Health,* Pargament and Brant (1998) explain that R-S coping can show up in many different ways, but ultimately involves an individual using R-S beliefs or practices to cope with distress. The literature generally divides R- S coping into two subgroups, "helpful" or "positive" coping, and "harmful" or "negative" coping (Koenig & Perez, 2000). In the year 2000 Pargament et al. developed a comprehensive measure for R-S coping known as the "RCOPE." They defined religious coping in respect to 5 key domains of religious function: Meaning, control, comfort, intimacy, and life transformation. Items may further fall into "positive" or "negative" coping. For example, under the domain of "meaning," one can find the helpful/positive coping statement "tried to see how God might be trying to strengthen me in this situation," as well as the harmful/negative coping statement "decided that God was

punishing me for my sins" (p. 522). Both involve coping with a situation by finding meaning through their R-S beliefs, but as Pargament et al. explain, specific negative coping strategies are "associated with greater distress, at least for the short term" (p. 525). The "Brief RCOPE" (B-RCOPE) is an abbreviated, 14-item version of the RCOPE, created to provide researchers and practitioners with an "efficient measure of religious coping which retained the theoretical and functional foundation of the RCOPE" (Pargament, et al., 2011, p. 56) (see Appendix A). A recent study by Roystonn et al. (2021) utilized the B-RCOPE to explore religious coping and quality of life in individuals experiencing psychosis. Of the 364 participants, 68.6% stated religion was "important," "very important," or "essential" in coping with their psychotic illness (Roystonn et al., 2021, p. 4). 15.7% stated it was of "some importance," and only 15.4% felt it was not important (p. 4). According to Roystonn et al., participants who utilized "positive religious coping" (as indicated by B-RCOPE) were more likely to score higher in the "physical" and "psychological" domains of quality of life (as indicated by the WHOQOL-BREF) (p. 5). "Negative religious coping" on the other hand was related to lower QOL in all four domains: physical, psychological, social and environment (p. 5).

A study by Rosmarin et al. (2013), which aimed to assess both suicidality and treatment outcomes in regards to R-S coping among patients with psychosis, found that negative R-S coping was associated with "substantially greater frequency and intensity of suicidal ideation," as well as increased levels of depression and anxiety, whereas positive religious coping was associated with a "significantly greater reductions in depression and anxiety, and increases in well-being" (p. 182). This research provides evidence that the B-RCOPE serves as a valid measure of R-S in individuals experiencing psychosis. According to Rosmarin (2018), the brief

RCOPE remains an appropriate measure to administer following his aforementioned assessment strategies and can help mental health practitioners with treatment planning.

R-S Competency in Treatment

As previously stipulated, R-S competency can be defined as the ability of a mental health practitioner to provide their services effectively to all clients, regardless of their R-S background, beliefs, or practices. Arguably, another component of such competency is a willingness to integrate an individual's R-S beliefs and practices *into* treatment. According to Rosmarin et al. (2013) individuals seeking mental health services are often eager to "address and incorporate [spiritual and religious] issues in the context of their treatment" (p. 425). For example, over one third of "acute psychiatric patients" report "moderate or greater interest" in incorporating their R-S beliefs and practices into treatment (Rosmarin et al., p. 425). Furthermore, the literature indicates that individuals with psychosis generally place great importance on their R-S beliefs and practices, and often use these beliefs and practices to cope, indicating that the integration of R-S beliefs and practices into treatment would be of great benefit to this population specifically (Roystonn et al., 2021). Of course, as with any intervention, collaboration is key. A mental health practitioner should never assume any given individual experiencing psychosis *wants* to incorporate their R-S beliefs and practices into treatment and should work collaboratively with the client to assess whether this is appropriate. As Rosmarin (2018) explains "collaboration ensures that the patient is comfortable with the use of [religion and spirituality] throughout the treatment process" (p. 109). If an individual experiencing psychosis with R-S themes wishes to incorporate their R-S beliefs and practices into their treatment, there are various ways to do this, including utilizing their explanatory framework in psychoeducation, incorporating R-S practices

and beliefs into pre-existing therapeutic modalities and interventions, and learning how to appropriately address harmful R-S coping in treatment.

Psychoeducation and R-S Explanatory Frameworks. Psychoeducation remains a fundamental part of treatment for many mental health concerns, including psychosis (Creek et al., 2015; Herrera et al., 2023). Unfortunately, individuals experiencing psychosis may struggle to gain insight into their illness, and on top of that, the line between "normal" R-S, and cultural beliefs and practices and psychosis can be blurry (Rosmarin, 2018), making psychoeducation for those with R-S psychosis particularly challenging. If mental health practitioners only provide psychoeducation in the form of biomedical explanations, they risk committing R-S incompetency, and decreasing the quality of care they are providing to their clients. "Explanatory models" or "explanatory frameworks" can be defined as the way in which an individual explains the underlying cause of their symptoms (Marriot et al., 2019). In the case of R-S psychosis, individuals are likely to use R-S explanatory models to understand and explain their experiences (Marriot et al.). According to Creek et al. (2015) in their guide, *A Shared Understanding: Psychoeducation in Early Psychosis,"*explanatory models are core to psychoeducation […] incorporating a person's explanatory model into psychoeducation helps the person feel understood rather than challenged about their belief system, which is likely to improve their engagement with treatment and the service." (p. 13). Creek et al., provide a step-by-step guide for practitioners (see Appendix B), which involves gathering information about an individual's explanatory model, finding "common ground," and then seeking ways to insert conventional psychoeducation and treatment planning into the individual's model (p. 14). A study by Marriot et al., (2019) which examined R-S explanatory models in individuals with psychosis through

semi-structured interviews, argue that mental health practitioners should value client's R-S explanatory models: "Services need to develop an acceptance that individuals who have psychotic experiences may have a good rationale behind their own frameworks, which can validly include religious aspects" (p. 88). They argue that mental health practitioners should "explicitly ask" how an individuals' R-S beliefs may be a part of their explanatory framework, and learn to work within this framework, versus only providing a biomedical explanation (Marriot et al., p. 87). They provide the following narrative from "Chloe," one of the participants in their study:

> I have, still have got my own questions about chemicals in [my] body getting out of hand and what I believe in […] a large of me does think that it was an evil spirit that, that's why I, that's why my body broke down (p. 84).

Here, Chloe is considering aspects of biomedical model previously presented to her, however, it is still her own R-S explanation ("evil spirits") which she assumes to be the underlying cause of her illness (Marriott et al., p. 84). One can imagine how Clark et al's., (2015) template could be implemented: This could look like continuing to gather information about Chloe's explanatory model, acknowledging her explanatory model in a respectful manner, and figuring out ways to provide accurate psychoeducation *within* her framework, for example, suggesting that medication and therapy can be helpful regardless of whether "evil spirits" influenced her symptoms. As Clark et al., (2015) explain "if [those around individual's with psychosis] challenge delusional beliefs, it leads to arguments, but if they agree with them, it may reinforce the beliefs" (p. 18). In this way, it is highly pertinent for those providing services and support to individuals with psychosis to find a *middle-ground,* i.e., knowing how to acknowledge and

respect the individual's delusions without whole-heartedly agreeing with, or promoting them. Psychoeducation remains a highly important tool in the treatment of psychosis, and mental health practitioners must make sure they are presenting information in a way that honours an individuals R-S beliefs regarding their illness. Learning to come alongside an individuals by stepping *into* their explanatory framework is core to practicing R-S competency both in psychoeducation, and treatment planning.

Incorporating R-S Practices and Beliefs Into Pre-Existing Therapeutic Modalities and Interventions. As previously discussed, there are various non-pharmaceutical interventions used in the treatment of psychosis, including counselling, family education, employment training, and various other community-based interventions (Frawley et al., 2023). According to Mohr (2011) integration of R-S practices and beliefs into psychiatric treatment can range from a "referral to chaplain, exploration of spirituality in individual and group psychotherapies, […] to holistic care programs." (p. 552). Mohr argues that every therapeutic approach can be successfully altered to integrate R-S beliefs. For example, The Centre for Spirituality, Theology and Health at Duke University (2014) published a series of Religiously-Integrated Cognitive Behavioral Therapy (RCBT) manuals for a variety of specific faith traditions including Islam, Christianity, Judaism, and Buddhism[19]. Mohr (2011) also discusses several specific group programs which integrate R-S beliefs and practices. For example, the *Spirituality Matters Group* is designed specifically for individuals with a diagnosis of schizophrenia and delivered in inpatient settings (Mohr). According to Mohr, the group utilizes R-S beliefs and practices to help individuals cope with their symptoms and hospitalization, while exploring "nondenominational

[19] See https://spiritualityandhealth.duke.edu/index.php/religious-cbt-study/therapy-manuals/ for free access to the manuals.

religious and spiritual themes," and working to address "prominent therapeutic concerns" throughout (p. 556). R-S themes can even be incorporated into family support, a core component of treatment for psychosis. Culturally Informed Therapy for Schizophrenia (CIT-S) is a family focused intervention composed of five modules which works to address cultural and R-S concerns[20] (Weisman de Mamani et al., 2010). CIT-S provides various family focused interventions, including groups, to help families both understand their loved one's symptoms, and utilize their own R-S beliefs and practices to help cope (Weisman de Mamani et al.). There are an endless number of ways that an individual's R-S beliefs can be incorporated into treatment. When mental health practitioners remain open to an individual's R-S beliefs and practices and work collaboratively with clients, they are more likely to find ways to safely and effectively integrate religion/spirituality into their treatment planning. This approach continues to cultivate R-S competency and produces better treatment outcomes for clients

Addressing Harmful R-S Coping. As has been discussed, R-S beliefs and practices may not always be beneficial in an individual's recovery journey. While it is key to continually practice R-S competency, it may feel exceptionally tricky when an individual is presenting with relatively extreme R-S presentations. For example, Fretheim (2015) provides the following case study:

> During episodes of psychotic depression, the patient had been in torment over his "sins," […] When his mood was elevated, he would pursue anti-abortion activities, occasionally becoming violent. He had delusions of grandeur relating to themes of God....He

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[20] See *Culturally Informed Therapy for Schizophrenia A Family-Focused Cognitive Behavioral Approach, Clinician Guide* by Weisman de Mamani et al. (2021).

> demanded to know if his psychiatrist was an abortionist […] The therapeutic relationship tended to fluctuate and trust was highly variable (p. 26)

In a case like this, it may be tempting to want to avoid the topic of R-S belief and practice all together. As Rosmarin (2018) explains, "some clinicians may be reluctant to promote [religiosity/spirituality] among patients who present with spiritual symptoms" (p. 59). When R-S beliefs and practices are perceived as potentially "contributing" to psychosis, practitioners may be concerned that incorporating these beliefs and practices is "adding fuel to the fire" (Rosmarin, p. 59). While this approach is understandable, merely avoiding R-S topics in treatment does not benefit recovery. As Maygar-Russell and Griffith (2016) argue, it is essential that mental health practitioners understand that R-S practices and beliefs can be "part of the problem" and "simultaneously be part of the solution to the problem" (p. 160). For example, Fretheim (2015) describes how R-S beliefs and practices were still incorporated into the aforementioned patient's treatment:

> Part of the therapeutic contract was to avoid direct action in anti-abortion activism for reasons to do with his personal safety. He agreed to the therapist's suggestion of constructive use of religious outlets at times of crisis. The patient appreciated opportunities to educate his psychiatrist about Catholicism (p. 27).

This excerpt provides a shining example of R-S competency: It appears the practitioner has found a middle ground with this individual, helping him to recognize which part of his R-S beliefs and practices may be hindering him (engaging in "anti-abortion activities"), while both holding space for his Catholic background, and incorporating positive R-S coping into treatment.

Although R-S beliefs and practices may at times, seem like a barrier to treatment, there are ways to effectively address harmful coping, while still maintaining R-S competency.

Chapter 3

Discussion

The modern healthcare system is beginning to acknowledge the importance of culturally competent care, and consequently, must also acknowledge the importance of R-S competency. Providing care that effectively addresses an individual's physical, emotional, cultural, and spiritual needs not only enhances their satisfaction with the care received but also improves treatment outcomes. Religion and spirituality are extremely important for many individuals globally, and especially for those who may be struggling with psychosis (Rosmarin, 2018; Roystonn et al., 2021). Psychosis can be characterized by a collection of different symptoms, including delusions (fixed beliefs that do not change in light of conflicting evidence), hallucinations (the presence of sensory perception in the absence of an external stimulus), and a wide range of emotional and behavioural changes, including depression, social isolation, and abnormal motor movement (APA, 2013). While psychosis is often associated with psychotic disorders like schizophrenia, it may also be a symptom of bipolar disorder, major depressive disorder, substance use, epilepsy, or a traumatic brain injury (APA, 2013; Devinsky, 2008; Hasan et al., 2020; Shrivastava et al., 2014).

Treatment for psychosis often involves the administration of antipsychotic medication, as well as psychosocial rehabilitation, such as counselling, family education, and work training programs (Frawley et al., 2023; Lecomte et al., 2014; Tsuda et al., 2022). Inpatient hospitalization for psychosis is common, particularly for individuals experiencing their first episode, and is frequently involuntary (Fenton et al., 2014; Lebenbaum et al., 2018; Wood et al., 2019). In Canada, psychotic disorders were the third most common reason for inpatient

hospitalization in 2019-2020, with an average length of stay of nearly 3 weeks (CIHI, 2021). The benefits of inpatient hospitalization are unclear, and it has been argued that inpatient psychiatric facilities often lack the ability to provide safe and appropriate care to patients (WHO, 2022; Wood et al., 2019). There is, however, evidence for the benefit of psychosocial interventions, especially those that are delivered in community settings, alongside an individual's family and/or community members (Frawley et al., 2023). Despite the evidence for these interventions, they remain under-utilized in many settings which provide care to those with psychosis (Lecomte et al., 2014).

A significant percentage of individuals experiencing psychosis will experience delusions or hallucinations with R-S themes (Cook, 2015; Rosmarin, 2018). Common R-S presentations in psychosis include hallucinations, such as hearing the voice of God, seeing angels, demons, or other spiritual beings, and delusions, such as maintaining the belief that one is the Messiah, or another important R-S figure (Fretheim, 2015; Grover et al., 2014; Rosmarin, 2018). While there is no indication that adhering to a certain R-S path increases the chances of developing psychosis with R-S themes (Rosmarin, 2018), the R-S content of delusions and/or hallucinations are often influenced by an individual's pre-existing faith background (Fretheim, 2015). For example, a Muslim individual may believe they see or hear Jinn, a Hindu may believe they can channel messages from Ganesha, and a Christian may believe they are the second coming of Christ. Furthermore, individuals experiencing psychosis will often use their R-S beliefs and practices to help cope with distressing aspects of their experience, regardless of whether their beliefs and practices are part of their symptomology or not (Roystonn et al., 2021). The literature generally divides R-S coping into two categories, "positive" or beneficial coping, and "negative" or

harmful coping. Positive R-S coping is associated with a decrease in distress and an increase in overall well-being and quality of life, whereas negative R-S coping is associated with an increase in anxiety and depression, an increase in suicidal ideation, and an overall lower quality of life (Rosmarin et al., 2013; Roystonn et al., 2021). The Brief Religious COPE (B-RCOPE) is a 14-item measurement used to assess whether an individual's R-S beliefs may be helping or hindering their recovery and has been used to successfully assess R-S coping in both the general population, and those experiencing psychosis (Rosmarin et al., 2013; Roystonn et al., 2021). It remains a practical tool to assist practitioners in assessing the R-S coping of the individuals in their care.

According to the literature, individuals who do experience psychosis with R-S themes are less likely to be satisfied with their care, and are less likely to adhere to treatment, leading to poorer treatment outcomes (Grover et al., 2014). Despite this association, research also demonstrates that engaging with one's R-S beliefs, practices and community can lead to better outcomes for those experiencing psychosis (Grover et al.). This seemingly paradoxical relationship is likely explained by the fact that many practitioners fail to provide adequate services to those experiencing psychosis with R-S themes, therefore reducing treatment adherence. Many individuals' experiencing mental health concerns, including psychosis, are interested in addressing R-S themes with their service providers (Rosmarin et al., 2013). Unfortunately however, research demonstrates that many practitioners lack the skills and knowledge to appropriately understand and address the R-S beliefs and practices of those accessing services, leading to both improper assessment, and inadequate treatment planning (Adenpole et al., 2012; Ayvaci, 2017; Huguelet et al., 2006).

Mental health practitioners can employ various strategies to practice R-S competency, thereby improving treatment outcomes for individuals in their care. Firstly, practitioners can try to gain general knowledge about an individual's faith tradition (Rosmarin 2018). This may involve a practitioner doing their own research about a given R-S tradition, or connecting with experts in their network, including R-S leaders, or spiritual care practitioners (CASC, n.d; Rosmarin 2018). Secondly, mental health practitioners can work to distinguish between pathological R-S beliefs and practices linked to psychosis, and genuine R-S beliefs and practices tied to established faith traditions (Rosmarin, 2018). This distinction can help practitioners better understand the individual's presentation, resulting in a more accurate assessment and improved care. Thirdly, practitioners can use valid and reliable measurements such as the B-RCOPE to establish which forms of R-S coping are helpful, and which are harmful (Rosmarin, 2018; Roystonn et al., 2021). Lastly, mental health practitioners can integrate an individual's R-S beliefs and practices into their treatment plan. This could involve using the individual's own R-S explanatory framework for psychoeducation, or, promoting positive R-S coping strategies and encouraging healthy engagement with their R-S community (Creek et al., 2015; Herrera et al., 2023; Rosmarin, 2018).

Application

This topic remains highly pertinent in the context of Canadian healthcare. Canada is a highly diverse country, encompassing a multitude of religions, spiritual beliefs, and cultural backgrounds (Vang, Hou, & Elder, 2019). Given this diversity, it is imperative for the healthcare system to be equipped to adequately serve individuals from all R-S and cultural backgrounds. Psychosis itself is a complex mental health condition that often necessitates intensive and

ongoing treatment (APA, 2013). Individuals experiencing psychosis are likely to receive services in a variety of settings, including inpatient, outpatient, and community-based care, and from a diverse range of practitioners, such as psychiatrists, psychiatric nurses, general practitioners, counsellors, and recreational therapists (Frawley et al., 2023; Lecomte et al., 2014; Tsuda et al., 2022; Wunderink, 2019). The literature highlights the critical importance of R-S competency among mental health practitioners. A lack of R-S competency can result in the misunderstanding, misinterpretation, or stigmatization of an individual's R-S beliefs and/or practices. This can subsequently lead to inaccurate assessment and diagnosis of the individual's condition (Adenpole et al., 2012; Ayvaci, 2017; Huguelet et al., 2006). Moreover, when practitioners are not adequately trained to comprehend and respect the R-S dimensions of their patients' experiences, they may inadvertently overlook vital aspects of the individual's coping mechanisms and support systems (Ayvaci, 2017; Huguelet et al., 2006). This oversight can result in inadequate treatment planning and, consequently, poorer treatment outcomes for those experiencing psychosis. While mental health practitioners consistently express interest in acquiring clinical skills related to religion and spirituality, they often struggle to find the time to engage with scheduled trainings (Bono et al., 2011; Rosmarin, 2013). One potential way to facilitate this is through the dissemination of a brief and easily accessible resource. Such a resource could provide essential knowledge and practical strategies for mental health practitioners to enhance their understanding and integration of R-S beliefs and/or practices into their treatment approaches, ultimately leading to improved treatment outcomes for those living with psychosis.

Pamphlet

The following pamphlet (see Appendix C) aims to provide a comprehensive summary of the findings from this literature review. It delves into the significant role of R-S beliefs and practices in psychosis, offering valuable insights into assessing these beliefs and practices, and suggests practical ways to enhance R-S competency among mental health practitioners. Additionally, the pamphlet includes a curated list of resources for practitioners to delve deeper into the subject, all of which are available online for free. Ideally, the pamphlet could be distributed across a variety of healthcare settings, including community health centres, physician's offices, and hospitals. It should also be made accessible online to reach a broader audience. Although the primary target audience for the pamphlet is mental health practitioners, the language and content are designed to be easily understood, making it a potential resource for friends and family of individuals experiencing psychosis. It can also be a valuable resource for those who may be experiencing psychosis themselves. While a one-page pamphlet cannot fully capture the complexity and nuances of this topics, it serves as a practical and informative starting point. The pamphlet aims to introduce practitioners to the concept of R-S competency, encouraging them to delve deeper into the subject and providing them with references for further reading at their own convenience.

Conclusion

The integration of R-S beliefs and practices into the care of individuals experiencing psychosis is a critical yet often overlooked aspect of mental health care. As the healthcare system increasingly recognizes the importance of culturally competent care, addressing the complex relationship between R-S beliefs and psychosis becomes glaringly important. Historically, R-S is a core part of human experience, inspiring philosophy, literature, and cultural movements. While

psychosis is often a distressing experience which requires treatment, the R-S experiences individuals may experience during psychosis can remain significant and meaningful to the individual and their relationship to their cultural and/or R-S background. R-S competency on behalf of mental health practitioners is a fundamental aspect of comprehensive and patient-centred mental health care. As the healthcare landscape continues to evolve, it is imperative for practitioners to embrace a holistic approach that respects and integrates the diverse R-S perspectives of their patients, ultimately leading to improved treatment outcomes for those living with psychosis.

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Appendix A

Table 2. The Brief RCOPE: Positive and Negative Coping Subscale Items.

Positive Religious Coping Subscale Items	
1.	Looked for a stronger connection with God.
2.	Sought God's love and care.
3.	Sought help from God in letting go of my anger.
4.	Tried to put my plans into action together with God.
5.	Tried to see how God might be trying to strengthen me in this situation.
6.	Asked forgiveness for my sins.
7.	Focused on religion to stop worrying about my problems.
Negative Religious Coping Subscale Items	
8.	Wondered whether God had abandoned me.
9.	Felt punished by God for my lack of devotion.
10.	Wondered what I did for God to punish me.
11.	Questioned God's love for me.
12.	Wondered whether my church had abandoned me.
13.	Decided the devil made this happen.
14.	Questioned the power of God.

Note. From "The Brief RCOPE: Current psychometric status of a short measure of religious coping," by Pargament, K. I., Feuille, M., & Burdzy, D., 2011, *Religions*, 2, 51–76.

Appendix B

BOX 1 NEGOTIATING EXPLANATORY MODELS

Elicit the young person and family's explanatory models.

Communicate the clinical model of psychosis to them in plain language.

Acknowledge and respect the young person's framework and the discrepancies between explanations that may exist.

Look for common goals or common ground.

Find a way to incorporate conventional treatment in the young person's explanatory model.

Note. From "A Shared Understanding: Psychoeducation in Early Psychosis." by Creek, R., Fraser, S., O'Donoghue, B., Hughes, F., & Crlenjak, C., 2015. Orygen, The National Centre of Excellence in Youth Mental Health.

Appendix C

Resources

The Canadian Association of Spiritual Care (CASC)
https://www.spiritualcare.ca

Providing Diversity Competent Care to Muslims: A Handbook for Health Care Providers
Fraser Health Authority, 2014

Providing Diversity Competent Care to People of the Sikh Faith: A Handbook for Health Care Providers
Fraser Health Authority, 2013

Caring for You: Body, Mind and Spirit Multi-Faith Prayer Book
Texas Health

Spiritual Care: A Multi-Faith Resource for Healthcare Staff
NHS Education for Scotland, 2021

To access this pamphlet online scan the QR code.

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Psychosis and Spirituality:

A Guide for Clinicians

Ciara Toddington, BA, MC (2024)

Religious and Spiritual **Symptomology**

- Religious and/or spiritual (R-S) beliefs and practices are often highly important in the lives of individuals with psychosis.
- Sometimes R-S beliefs can be *part of* an individual's psychotic illness. For example, up to 22% of those diagnosed with bipolar disorder, and 39% of those diagnosed with schizophrenia will experience delusions and/or hallucinations with R-S themes. [2]
- R-S symptoms are often influenced by an individaul's faith background. This can make it difficult for clinicians to differentiate between pathological beliefs and practices, and those which are normal in an individual's faith tradition.

Religious and Spiritual **Coping**

- Individuals with psychosis may use their R-S beliefs and practices to cope with distressing aspects of their illness. This is known as *religious or spiritual coping*
- The literature generally divides R-S coping into *positive* or helpful coping, and *negative* or harmful coping.[3]
- Positive R-S coping is associated with better treatment outcomes, where as negative R-S coping with poorer outcomes.[4]
- Measurements such as the B-RCOPE can help clinicians differenciate between which R-S beliefs and practices may be helpful and which may be harmful in an individual's recovery journey.[5]

Religious and Spiritual **Competency**

- Much like cultural competency, R-S competency is necessary to provide safe and appropriate care to service users.

Tips for practicing R-S competency:

- Gain knowledge about different R-S traditions. This could involve reading about certain faith backgrounds, or connecting with R-S experts in your network, such as faith leaders, or spiritual care practitioners.
- Work to differentiate between positive and negative R-S coping and support clients in utilizing positive R-S coping strategies .
- Recognize the importance of R-S beliefs and practices in an individual's life. Just because someone is struggling with psychosis with R-S themes does not mean all of their R-S beliefs and practices are harmful to their recovery.