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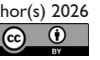

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Listening to Sacred Stories: How Clinicians Navigate and Understand a Patient's Religious Experience

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Abstract

Religion and spirituality (R/S) in mental health care has gained growing recognition, with institutions such as the Nation Health Service, World Health Organization, and World Psychiatric Association emphasizing its significance in clinical practice. However, limited attention has been given to how mental healthcare clinicians understand and interpret patients' religious experiences. This study explores clinicians' interpretive frameworks and practices using a hermeneutic-phenomenological approach and semi-structured interviews with eight UK-based clinicians (psychiatrists, psychologists, and CBT practitioners). Transcripts were analyzed both thematically and structurally, guided by the Four Voices of Theology. Findings are discussed through the lens of the Four Voices of Theology and offer insights into how clinicians negotiate meaning, context, and diagnosis regarding religious experiences. This research enhances understanding of clinician–patient engagement around R/S and highlights the need for more reflective, context-aware approaches in mental health care.

Keywords

religious experience, clinical practice, mental health, religion and mental health, religion and psychopathology

Introduction

Over the last few decades, medical, psychiatric, and psychological literature has emphasized the need for clinicians to understand and address an individual's religious and spiritual (R/S) needs as a part of a holistic approach toward patient care and treatment (Abdulla et al., 2019; De Diego-Cordero et al., 2023; Harris et al., 2016; Klitzman, 2021; Koenig, 2013b; Kumar et al., 2019). This growing recognition not only emphasizes the clinical relevance of R/S issues but also calls for clinicians to engage with such phenomena thoughtfully and non-reductively (Koenig, 2013b; Vieten et al., 2023).

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R/S beliefs and encounters have been recognized as playing a significant role in shaping human identity, values and meaning-making (Kao et al., 2020). In the context of mental health, these experiences can profoundly influence the onset, experience, and recovery from mental distress (Cook et al., 2011; Dein et al., 2012). Recent studies continue to affirm this connection: Holma et al. (2024) demonstrated that spirituality supports the recovery from mental health challenges by fostering connection, meaning, and emotional resilience; Winfrey (2025) found that integrating spiritual care into mental health services improves outcomes and enhances quality of life, and Cucchi and Qoronfleh (2025) argue that spirituality offers culturally embedded frameworks for understanding suffering and healing. While many individuals report that religious experiences may bring comfort, meaning, and spiritual growth (Koenig, 2013a; Pargament & Raiya, 2007), others may find such experiences confusing, distressing, or destabilizing—particularly when they intersect with symptoms of mental illness. In this study, R/S encounters refer to moments in which patients describe direct experiences of the divine or transcendent—such as visions, voices, or spiritual revelations—that clinicians must interpret within a clinical context.

The clinical significance of R/S in mental health

R/S has become increasingly recognized as meaningful dimensions of what it means to be human by prominent organizations such as the Nation Health Service (NHS) (Office for Health Improvement and Disparities, 2021; Swinton et al., 2022) and the World Psychiatric Association (WPA) (Moreira-Almeida et al., 2016) affirming that "spirituality and religion are concerned with the core beliefs, values and experiences of human beings." Such organizations recognize spirituality as a core dimension of human identity and well-being. Moreover, it has been found that psychiatrists are more likely to encounter R/S concerns in clinical settings than any other form of healthcare provider (Curlin, Lawrence, et al., 2007; Curlin, Odell, 2007). Despite this, engagement with these experiences remains limited, inconsistent, and entirely reliant on the clinician. Consequently, it is important to recognize that there is not only a tension between the organizational push to involve patients in these experiences but also a lack of comprehensive frameworks for clinicians to do so. For example, the *DSM*-5 acknowledges that religious or spiritual experiences can be misinterpreted as pathological or may occur within the context of mental illness. This underscores the complex nature of the issue and emphasizes the need for clinicians to thoughtfully consider and engage with patients' religious beliefs and experiences, rather than dismissing or pathologizing them.

While the DSM-5 (American Psychiatric Association, 2013) includes a category for "Religious or Spiritual Problems," acknowledging that religious experiences can be mistaken for, or occur alongside psychopathology, clinicians still face challenges in interpreting and responding to these experiences.

Existing literature highlights several potential reasons for this gap. For example, psychiatrists tend to be less religious than other physicians (Curlin, Lawrence, et al., 2007; Koenig, Peteet, & VanderWeele, 2020; Vieten et al., 2023). van Nieuw Amerongen-Meeuse et al. (2018) describe a "religiosity gap" between clinicians and their patients, which may inhibit deeper engagement with patients' spiritual narratives. Menegatti-Chequini et al. (2020), in a study of Brazilian psychiatrists, found that clinicians' religiosity strongly influenced how they addressed R/S in clinical practice—more religious psychiatrists were more likely to incorporate R/S perspectives, while less religious clinicians tended to avoid the topic altogether.

Koenig (2008) demonstrated that surveys reveal that many psychiatrists, particularly in the United Kingdom, Canada, and the United States, maintain a degree of skepticism toward integrating religion into clinical practice. More recent studies confirm this trend while adding nuance. Although most mental health professionals—including psychiatrists—recognize the relevance of R/S in clinical care, nearly half report limited formal training and discomfort with integration

(Vieten et al., 2023). Clinicians often remain uncertain about how to incorporate R/S meaningfully, despite its potential benefits (Koenig, Al-Zaben, & VanderWeele, 2020).

In the UK context, Poole et al. (2019) found that within psychiatry, there is still a consensus that patients' R/S lives are legitimate topics when it comes to assessment and the therapeutic relationship. They emphasize the need for carefully thought-out and nuanced approaches to R/S issues in the therapeutic relationships and warn against the avoidance of these topics as "neglect of this specific issue has led psychiatry into serious error in the past, and will do so in future unless we take active steps to avoid it" (Poole et al., 2019, p. 182).

A recent mixed-methods study by Poole et al. (2023) builds on this, showing that UK psychiatrists continue to express uncertainty about how to engage with R/S in clinical practice, particularly around professional boundaries. While there was consensus that evangelizing is inappropriate, many clinicians expressed uncertainty on how to respond to patients' spiritual concerns, and few referenced their own religious beliefs, highlighting ongoing discomfort and lack of clarity in this area. These findings suggest that while professionals acknowledge the importance of R/S, they often lack the tools or confidence to incorporate these dimensions into treatment. Personal belief systems, cultural context, and diagnostic frameworks all shape how clinicians interpret R/S expressions in their patients.

Although there is a growing consensus that R/S should be considered in patient care, limited research has explored how clinicians perceive and religious experiences, particularly when such experiences overlap with symptoms of mental illness (Salem & Foskett, 2009). This study addresses that gap by examining the interpretive frameworks clinicians use when encountering complex, often ambiguous experiences in practice.

Theoretical lens and contribution

To explore these dynamics, this study draws on a practical theological framework—specifically, the "Four Voices of Theology" (Cameron et al., 2010)—to understand how clinicians interpret patients' spiritual narratives. The Four Voices framework distinguishes between four interwoven but distinct theological perspectives: (1) *operant voice*: what people do in practice, (2) *espoused voice*: what people say they believe, (3) *normative voice*: formal teachings or institutional expectations, and (4) *formal voice*: academic, theological reflection.

These voices are not isolated but continuously interact—sometimes reinforcing, sometimes contradicting one another. They help illuminate the tensions between clinicians' stated values, institutional norms, and actual clinical behaviors. This framework is particularly useful for analyzing how spiritual content is engaged with, avoided, or reframed in clinical settings, and for understanding the interpretive complexity, clinicians face when navigating religious experience in practice.

Practical theology is concerned with interpreting lived experience in light of theological traditions and offers a critical yet constructive lens through which to examine the hermeneutics of clinical practice (Swinton & Mowat, 2016). By bringing this interdisciplinary approach into conversation with the findings, the study not only analyzes clinicians' language and practices but also reflects on the broader ethical and epistemological questions raised by encounters with R/S experiences.

Research aims and questions

This study explores how clinicians in mental health settings understand, interpret, and respond to their patients' religious experiences. Specifically, it asks:

- How do clinicians perceive and make sense of patients' religious experiences?
- How do diagnosis, context, and clinicians' belief systems shape interpretation?

- What emotional, professional, or epistemological challenges arise in engaging with these experiences?
- How might theological and interdisciplinary frameworks support more nuanced clinical engagement?

Methods

A short note on epistemology

As the principal investigator of this research, I adopted a critical realist stance to guide the design, conduct, and analyze the project. This epistemological position recognizes that reality exists independently of our perceptions, but it is always interpreted through socio-cultural and individual lenses. This stance was fitting for the project given the multicultural backgrounds of clinicians and the diversity of their world views. It enabled me to approach participants' perspectives of patients' R/S experiences not only as objective facts but also as situated, constructed understandings that are continually shaped by religious, cultural, social, and clinical contexts. As such, the data given by participants regarding such encounters will be treated as a variety of perspectives rather than as objective facts.

This provided epistemological coherence throughout the research project, ensuring consistency between the research aim, method, interpretive approach, and analysis of data. The critical realist orientation also shaped the development of interview questions, the analysis of transcriptions, and the way I handled contradictions in participant narratives, recognizing the information as personal reflections that are deeply influenced by layers of social realities, rather than as inconsistencies that need to be addressed and resolved.

Research design

This study employed a qualitative research design to explore how mental health clinicians perceive and understand patients' R/S experiences. A hermeneutic-phenomenological approach was chosen to capture the lived experiences and interpretative processes of clinicians. This method allowed for deep engagement with the complex, subjective, and nuanced nature of meaning-making, which was central to the study's focus.

Hermeneutic phenomenology, rooted in the philosophical work of Heidegger and Gadamer, emphasizes that understanding is always interpretive, contextual, and shaped by the background of both the participant and the researcher. Unlike descriptive phenomenology, which seeks to bracket assumptions and describe phenomena as they appear, hermeneutic phenomenology acknowledges that interpretation is inherent to understanding. This was crucial for exploring clinicians' perceptions, which are shaped by their professional training, cultural context, and personal beliefs.

This approach was particularly suited to the interdisciplinary nature of the study, enabling theological and psychological insights to co-exist without privileging one over the other. Hermeneutic phenomenology provided a methodological space where multiple epistemologies could be held in tension—allowing spiritual discernment and clinical reasoning to be explored side by side. For example, clinicians' narratives were analyzed with sensitivity to both theological meaning-making (e.g., divine encounter and spiritual struggle) and psychological constructs (e.g., diagnostic framing and therapeutic engagement), fostering a richer, layered understanding.

The use of hermeneutic phenomenology also aligns with a critical realist stance, reinforcing an understanding of human experiences as both real and socially constructed. Clinicians' interpretations of religious experiences were treated as situated and meaningful, shaped by cultural, clinical, and personal epistemologies. This methodological fit enhanced thematic depth and conceptual clarity during analysis. It was selected over other qualitative approaches (e.g., grounded theory or

narrative inquiry) because the goal was not to generate new theory or capture life stories, but to illuminate how meaning is made and enacted in clinical settings around religious and spiritual themes. Reflexivity was also central to the process: the researcher's own theological and psychological background was acknowledged as part of the interpretive lens, in line with hermeneutic phenomenology's emphasis on situated understanding.

Participants

The study recruited eight mental healthcare clinicians through professional networks, word-of-mouth, and a social media call. Participants comprised six women and two men, with an average age of 40. Participants had between 10 and 40 years of professional experience. Areas of employment included psychiatry, clinical psychology, counseling psychology, and cognitive-behavioral therapy. Participants reported various religious affiliations: four identified as Christians, one Muslim, one Sikh and the final two identified as not belonging to a particular religion.

The sample was ethnically diverse: 49% White, 37% Black, and 12% Indian participants. The professional environments of participants involved working on acute psychiatric wards, community mental health clinics and some in private practice. Most clinicians specialized in treating depression, anxiety, and trauma, with the use of Congitive Behavioral Therapy (CBT) and Psychodynamic therapy.

Data collection

Semi-structured interviews were conducted via Zoom and lasted between 57 and 75 minutes (average 68 minutes). These in-depth interviews allowed participants to articulate their experiences, personal thoughts, and reflections on a topic that most stated they don't often have a space to express. Six questions were used, allowing for flexibility in responses and opportunity for follow-up questions. These were as follows:

1. How do you feel about discussing a patient's religious or spiritual experience in your practice?
2. How do you approach understanding a patient's religious beliefs and experiences when addressing their mental health challenges?
   (a) Can you share any instances where a patient religious/spiritual beliefs have significantly influenced their mental health challenge or recovery process?
   (b) Does your approach different depending on the diagnosis a patient has?
3. How do you differentiate between culturally influenced behaviors and genuine religious experiences when working with patients from diverse backgrounds?
4. How do you personally differentiate between religious experiences that support a patient's mental health and those that may exacerbate any difficulties?
5. In your opinion, how can clinicians strike a balance between respecting a patient's religious beliefs and ensuring evidence-based mental health interventions are undertaken.
6. What resources or training would be helpful for clinicians to better understand and address the intersection of religious experiences and mental health in their practice?

This method was chosen to enable deep engagement with the phenomenon, particularly since religion and spirituality are often described as ineffable, or "too deep for words" (Blazer, 2009, p. 282).

All the interviews were audio-recorded with participant consent and transcribed verbatim. Observational notes were taken during interviews and immediately after each interview to capture non-verbal cues and contextual details of the interview. These notes contributed to data triangulation and helped support a more holistic interpretation of the data. Interview questions were piloted

with two colleagues to refine clarity and sensitivity, ensuring they invited expansive, nuanced, and reflective responses.

Data analysis

Data were analyzed using NVivo software. Two interrelated processes guided the analysis: (1) coding and (2) interpretive analysis. Coding focused on systematically organizing the data, while interpretative analysis aimed to develop themes and interpretative frameworks of the data. These processes are described below.

Coding process

Braun and Clarke's (2006) six-phase framework provided a structured process for identifying and refining themes, while Saldaña's (2016) two-cycle coding approach enabled a deeper conceptual layering of the data. In practice, initial codes were generated using Braun and Clarke's method, focusing on semantic content and recurring patterns. These were then re-coded and clustered using Saldaña's approach to identify latent themes and epistemological tensions.

This iterative process involved familiarization, initial coding, theme development, review, definition, and final reporting. In the first cycle, descriptive codes were generated around clinicians' language concerning diagnosis, belief systems, and clinical practice. These were refined in the second cycle into conceptual clusters that reflected broader epistemological and theological themes.

Patterns were selected based on frequency, emotional intensity, and relevance to the research questions, with particular attention to moments of contradiction or epistemic tension. During initial coding, attention was paid to moments where clinicians expressed uncertainty, contradiction, or emotional resonance—particularly around diagnosis and spiritual interpretation. Codes were prioritized when they revealed interpretive complexity or highlighted epistemological friction, such as when clinicians struggled to distinguish between pathology and genuine R/S experiences.

Interpretative analysis process

Analysis processed in two stages. Stage 1 involved thematic clustering, producing three overarching themes and sub-themes. Stage 2 applied a hierarchical interpretive framework to explore the layered nature of meaning-making and the broader influence of cultural and clinical models. The hierarchical interpretive framework refers to a layered analytic structure that reflects how multiple levels of influence shape clinicians' meaning-making processes.

The Four Voices of Theology (Cameron et al., 2010) were then applied as a meta-interpretive framework to explore tensions between clinicians' stated beliefs, institutional norms, and actual clinical behaviors.

The principal investigator conducted all data analysis. While coding and theme development were undertaken independently, two colleagues with expertise in qualitative research and theology provided feedback on the coding framework and thematic structure during peer debriefing sessions. This collaborative input helped refine the interpretive lens and enhance analytical rigor.

Reflexivity

The researcher acknowledged potential interpretive biases that could arise during interviews, such as personal perspectives on religious traditions, culture, and spirituality, which could influence data interpretation. Ongoing reflexive journaling and memo taking were employed throughout the research project to critically examine and mitigate these biases and recognize my positionality.

Ethics

Ethical approval was granted by the University of Aberdeen Ethics Committee. All participants provided informed consent before participation, confidentiality was ensured throughout the research process, and participants were made aware they could withdraw from the research at any stage.

Ensuring trustworthiness

To enhance the rigor of this qualitative study, strategies were employed to ensure trustworthiness across four key criteria:

- **Credibility**: Achieved through prolonged engagement with data, participant diversity, and peer debriefing during the analysis process. Peer debriefing involved regular consultation with an academic colleague during the coding and analysis phases. These sessions provided critical feedback on emerging themes, challenged interpretive assumptions, and helped ensure that the analysis remained grounded in the data. This process enhanced credibility by introducing external perspectives and reducing potential researcher bias.
- **Transferability**: Enabled by providing detailed descriptions of participant contexts and clinical settings.
- **Dependability**: Supported through systematic documentation of all methodological decisions and coding procedures.
- **Confirmability**: Reinforced via reflexive journaling and the use of an audit trail to ensure findings were grounded in the data rather than researcher bias.

Results

The Results section presents the findings from the semi-structured interviews and explores how participants perceive and interpret their patients' R/S experiences. Fourteen frequently occurring codes were analyzed and organized into interpretative clusters. The clustering aimed to provide a descriptive account of the findings and a platform for theoretical and practical interpretations.

Stage 1: Thematic clustering

The results were analyzed thematically, which generated three overarching themes with several sub-themes. These themes reflect clinicians' meaning-making processes as they navigated the interplay between religious experiences and mental health challenges/diagnoses. Table 1 presents a summary of the themes and sub-themes that have been explored.

Theme 1: Epistemologies and models of understanding. Participants frequently described the frameworks they used to make sense of religion, patient experiences, and clinical diagnosis—emphasizing how multiple models such as biomedical paradigms, cultural narratives, context, and theological interpretations often intersected in their thinking. There was a strong awareness that, at times, these models are in tension with one another and, as such, could lead to a reductionist or incomplete understanding of the patient's experience.

Participant 5 reflected, "There's a lot that we can't see and know without the kind of sensors that we have, and a lot that is not explainable in psychology. It's just one lens to make sense, and it's a useful lens. But it's one lens among many to make sense of people's experiences." This acknowledgment of the limits and at times reductionist nature of clinical epistemology was echoed by other

Table 1. Themes Identified in Participant Interviews (Interpretive Clusters).

Thematic cluster	Codes included	Interpretative notes
Epistemologies and models	Models of understanding, cultural differences, context, openness to new beliefs, personal worldviews	Participants discussed making sense of experiences through layered models of understanding that were deeply influenced by culture, religion, theology, and clinical norms.
Experiential and subjective	Personal experience, psychosis, spirituality, curiosity	Lived experiences are often ambiguous and difficult for participants to articulate; they are understood across various frameworks.
Clinical practice	Clinical practice, therapeutic relationship, diagnostic differences, asking questions, training	Practical implications for clinicians: how frameworks shape diagnosis, rapport, understanding of spiritual experiences and treatment paths.

participants, who highlighted the need to attend to personal and contextual details of the patient more fully.

Cultural understanding also emerged as a central concern and area of epistemological influence for participants. Participants noted the need to engage in additional work and study to understand a patient's background, and how this then influenced diagnostic clarity and understanding of an individual's experiences. As Participant 2 explained,

> I would need to find out more information from them [about their cultural beliefs and experiences] . . . you know, what kind of thing typically happens in their culture? How do they approach situations like this? What does it mean? How do I use their culture to help me to start to understand them.

Similarly, Participant 3 highlighted the epistemological challenge of distinguishing cultural norms from pathology: "the key thing is for me is, you know, working out the psychopathology really. Is this a religious belief which, regardless of whether I agree with it or not, would be culturally appropriate and therefore not delusional?"

Finally, Participant 4, a psychiatrist, provided a comparative lens by reflecting on their experiences practicing in both the United Kingdom and Nigeria. They observed that in the United Kingdom, R/S experiences are often under-discussed or marginalized in clinical encounters. In contrast, patients in Nigeria were more likely to frame illness in terms of spiritual warfare, curses, or witchcraft—narratives that were not only acknowledged but also integrated into treatment approaches. This comparison underscored how culturally embedded epistemologies profoundly shape both clinical understanding and therapeutic strategy.

Theme 2: Experiential and subjective. This theme explores clinicians' reflections on the personal, emotional, and spiritual components of their patients' experiences, particularly as they come into play with psychosis. Participants spoke of the challenges of interpreting these experiences as they blur the boundary between pathology, religion, and meaning-making. Several clinicians highlighted the deeply personal and subjective nature of R/S experiences, suggesting that these experiences cannot be understood through a purely medical or clinical framework alone. Participant 4 stated the importance of "discussing the religious experiences of the patient because that might be a hallmark of presentation and be important to recovery. So as much as possible, I discuss it in practice."

The importance of discussing a patient's R/S experiences—both those experiences as comforting and those as distressing—was emphasized across interviews. Participant 2 described a case where religious experiences became a key source of comfort and recovery for a patient:

> She was a very strong Christian, and she was always praying . . . It was just so helpful in everything she was going through . . . on the ward, she had a circle of all the other patients and clients she was praying for. And it really helped her; she did recover . . . we allowed her to express herself and spoke about what the angels are saying and how they are helping her. And she was able to use her experiences to help in her recovery. And I think it was one of the most beautiful things that I saw during my time of work.

In contrast, Participant 5 described a patient who had psychosis and discussed visions of the devil. The clinician reflected on their initial discomfort and emotional responses:

> I struggled to work with him, I found his eyes very scary, and he was really, I don't want to use the word disturbed but in a state of terror and that did scare me. And I felt, honestly, he was seeing something that wasn't a hallucination, something other people couldn't. I do think he was seeing stuff. Not necessarily the devil, but some kind of spiritual darkness.

Unlike other participants who discussed both positive and negative experiences of religion in their patients, in this instance, the participant didn't attempt to contextualize the patients' experience. Participant 5 never clarified what the patient was experiencing; the experience remains unresolved, leaving the participant with uncertainty about what occurred. While the participant perceived the patient's experience as genuinely dark, they acknowledged uncertainty about its spiritual dimension. This highlights the interpretive limits clinicians may encounter when faced with phenomena that fall outside of their medical framework but evoke a strong emotional or spiritual response.

Several clinicians reflected critically on their limitations and previous hesitations discussing spiritual matters in a clinical setting. Some admitted they had at times avoided conversations altogether or trivialized the patients' experiences because they were uncomfortable. With hindsight, they recognized that this may have limited their ability to support and understand patients holistically and as one participant discussed working with a very religious individual and stated:

> I kind of pushed everything to the side really [the religious and spiritual stuff], which led to a bit of a breakdown in the relationship with him therapeutically . . . however my assistant was able to discuss spiritually and work with him on his spiritual beliefs and religious experiences and he really opened up to her . . . and that was when I realised that I was coming at the problem from a very clinical perspectives about [his] beliefs and I found it really challenging because my existing training didn't allow me to incorporate those beliefs into the way that I was trying to work in a model that was very structured and reductionistic. Whereas my assistant, who wasn't so well trained, could engage more.

By contrast, Participant 7 described a more integrative approach to understanding a patient's religious life and comfort that was not present for the previous clinician:

> I wouldn't see [religion] as a separate entity, that now we've talked about your religious belief, let's talk about your mental health. It's getting to know all the dimensions of the person and their religious belief, mental health, hobbies and interests are all part of that . . . I get to know what's important to the person.

This theme reveals not only the deep personal affect and complexity of R/S experiences for clinicians, but also the evolving attitudes and epistemological frameworks clinicians must navigate when engaging with R/S experiences. As such, these frameworks—shaped by training, personal views, and experiences and professional forms—mediate the degree to which such experiences may be understood as meaningful, perhaps problematic or outside the bounds of clinical interpretation.

Theme 3: Clinical practice and professional reflectivity. This theme explores the ways clinicians' practices are shaped by their professional frameworks, diagnostic training, and the relational dynamics that occur in a clinical setting. Participants reflected on how their approaches to diagnosis, rapport-building, and engagement with R/S content was influenced not only by institutional protocols but also by their personal comfort levels, past training, and perceived professional boundaries. For example, as discussed in Theme 2, Participant 1 acknowledges the tensions between clinical objectivity, medical models, and the subjective, often deeply meaningful experiences, patients' experiences. Their reflection highlights how strict adherence to medical or reductionist models can inhibit clinicians from engaging with patients' religious narratives, especially when such narratives fall outside conventional psychiatric categories.

Other participants discussed the importance of openness when working with individuals with different beliefs. Participant 6 stressed that subtle clinician behaviors can inadvertently signal disapproval, disinterest, or disbelief toward their patients:

> I think therapists and mental health professionals need to be mindful of how they conduct themselves. Because if someone says something you don't agree with or believe, you don't want to be pulling a disapproving face or saying something, that adds to the problem [of not discussing R/S].

They went on to emphasize the importance of having these conversations "because if you avoid the conversations that's dismissive in itself . . . not making space for important aspects of someone." This points to a broader concern among the participants regarding the unspoken norms within mental health practice—norms that may inadvertently pathologize, minimize, or marginalize religious discourse and explain it away as purely illness. Several expressed a growing awareness and concern that their training had not adequately equipped them to navigate these themes, leaving them feeling ill-prepared to incorporate them into their clinical practice.

Participant 8, for example, noted how they were at times unsure where the boundaries were in discussing religious content and, as such, avoided these discussions. Others expressed confidence to engage with religious themes, but stressed this came out of their learning and experiences in these areas, not from any form of training.

Taken together, these reflections point to a need for more intentional training on the R/S dimensions, especially regarding how to engage with them in a therapeutic relationship. They also note the discomfort of some clinicians and the importance of ensuring that all mental healthcare clinicians feel confident and competent when dealing with such encounters.

This clustered thematic approach is utilized to separate the lenses through which people understand patient experiences from the patient's context and themselves, and how those interpretations are then manifested and impact clinical practice.

Stage 2

Having developed the thematic clusters in Stage 1, Stage 2 moves toward a more interpretative and layered understanding of the findings. This stage explores how the themes relate to one another and reveals a spiral-like structure of meaning-making. At the base are clinicians' epistemologies and models of understanding (Theme 1), which shape how they interpret patients' religious experiences. These interpretations then influence how clinicians engage with the emotional and subjective aspects of those experiences (Theme 2), which in turn inform clinical decisions, and interactions (Theme 3). This process is not linear but recursive—each layer builds on and reshapes the others, forming a hermeneutic spiral of interpretation that deepens over time and through reflection.

At the base level, clinicians engage with patients through observable behaviors and interactions (clinical practice). These are shaped by deeper interpretative frameworks (epistemologies/models), which are themselves informed by broader cultural, spiritual, and personal meaning-making

processes (experiential/subjective). These layers do not exist in isolation but interact dynamically, informing the way clinicians interpret R/S content and integrate it—or fail to integrate it—into therapeutic encounters.

This structure also highlights a significant disjunction between what clinicians say they value (espoused beliefs about holistic care, cultural sensitivity, patient-centeredness) and what they do in practice (often avoidant, medicalized, or disconnected from spiritual discourse). This tension provides a critical lens through which to analyze both the ethical and theological implications of clinical engagement with R/S experience.

This layered structure can be visualized as follows:

1. Foundational Layer—Epistemologies and Models of Understanding: These provide the cognitive, cultural, and professional frameworks through which clinicians understand and conceptualize R/S experiences.
2. Interpretive Layer—Experiential and Subjective Meaning-Making: This layer reflects how those frameworks are applied to the lived, emotional, and sometimes ambiguous experiences of patients.
3. Practical Layer—Clinical Practice and Interaction: This top layer encompasses the tangible implications in diagnosis, rapport-building, communication, and therapeutic planning. Simply, how does all of this play out in action and reflection?

This hierarchical model reflects not only the structure of meaning-making in the data but also foreshadows the discussion, where findings are interpreted theologically using the Four Voices of Theology (Cameron et al., 2010). This framework helps illuminate tensions between clinicians' stated beliefs, institutional norms, and clinical behaviors.

Discussion

This research aimed to explore how mental healthcare clinicians understand and interpret their patients' R/S experiences. Through thematic and hierarchical analysis, the findings demonstrated a layered interpretative process in which it becomes clear that mental healthcare clinicians draw upon multiple epistemological models to navigate the personal and affective nature of R/S experiences, and ultimately, how these understandings impact clinical practice.

Thematic analysis of interviews reveals three core themes: (1) epistemologies and models of understanding, (2) experiential and subjective dimensions, and (3) clinical practice. Together, these themes reflect the ongoing complexity of meaning-making for clinicians, particularly regarding the influence of a clinician's background, religious literacy, and comfort with spirituality (Koenig, 2008; Menegatti-Chequini et al., 2020). The hierarchical analysis in Stage 2 situates epistemology/models of understanding as a foundational lens shaping clinicians' interpretative frameworks. For instance, a clinician's upbringing or familiarity with a particular faith may facilitate greater empathy and understanding with their patient. Unfamiliarity or negative past experiences may either inhibit engagement or lead to misunderstandings. These frameworks inform clinicians' capacity to interpret subjective R/S experiences and ultimately shape the contours of clinical engagement.

However, while the clinicians who participated in the research expressed an ongoing commitment to person-centered, holistic care, the findings illustrate a fragmented relationship between espoused values and operant behaviors. This fragmentation comes largely due to systemic and biomedical constraints and frameworks that clinicians work within. The Four Voices of Theology (Cameron et al., 2010) offers a unique lens to examine this research and how theological and medical assumptions—conscious or unconscious—shape clinical interaction.

The Four Voices distinguishes between four interwoven but distinct theological voices: (1) operant voice (what people say and do), (2) espoused voice (what people say they believe), (3) normative voice (formal religious teachings and doctrines), and (4) formal voice (academic theology). Cameron et al. (2010) emphasize that these voices do not operate in isolation, but are continuously entangled in practice, sometimes reinforcing, contradicting, and challenging one another. Applying this framework to these findings allows us to trace not only what clinicians have said they do in relation to patients' R/S experiences, but also how guidelines (e.g., NHS, WHO, and APA policies) may express normative and espoused commitments to care that clinicians struggle to either realize or implement in practice. It also reveals how clinicians' actions may align with, resit, or reinterpret broader theological narratives, whether consciously or not.

Operant and espoused voices: The tensions between intention and action

The operant voice reveals how clinicians *actually behave* in practice—their language, body language, clinical decisions, and interactions with patients. While clinicians frequently described themselves and their demeanor toward patients as open and respectful when it comes to R/S, their accounts also disclose routine avoidance of these topics. One clinician admitted, "it's like we don't want to delve into that (R/S)," while another interviewee described their colleagues rolling their eyes when patients discussed R/S matters. This implicit discomfort and continued avoidance reflect a gap between the internalized professional ideals and values and day-to-day contact with patients.

This is particularly noticeable in cases of psychosis, where clinicians often frame R/S experiences through a biomedical lens, interpreting visions or voices as purely symptoms of psychopathology, without allowing for them to be meaningful or transformational narratives and formative experiences for their patients. Interestingly, each clinician who participated in the research discussed this tension between R/S experiences and psychosis, but did not have as clear-cut lines about what is a symptom of psychopathology and not a R/S experience when it came to experiences during either depressive or manic episodes. By only ever analyzing these experiences through a purely biomedical or illness perspective, clinicians may inadvertently dismiss or pathologize patients' R/S experiences, belittling or dismissing encounters that may become truly transformational and positive for the patient. In doing so, the clinician risks participating in epistemic injustice (Scrutton, 2017; Porcher, 2024; Cullinan et al., 2024) where individuals are deprived and disbelieved about their meaning-making interpretations of their own experiences, and what these experiences mean for them and their flourishing.

This highlights that though clinicians may say they are open and willing to engage with these experiences, when you ask them more detailed questions in interviews, you find that their actual actions differ from what they say they do or how they would like to act. For example, they may avoid engagement altogether. This shows how even in practices and in disciplines that emphasize the need for engagement with R/S, it can be viewed as private, potentially risky or even irrelevant to the patient experiences and treatments. This suggests a tension between a clinician's espoused beliefs—their expressed desire to be open, curious, and respectful—and their operant beliefs, shaped by institutions and a lack of training.

One interviewee reflected on this cognitive dissonance: "there is a spiritual realm in the world . . . so it's an open-mindedness and a curiosity to really go there with people . . . especially when I've not done that in the past . . . I think it is actually really important work for us to bring that in." This moment of self-awareness emphasizes two main points. First, there is a desire among some clinicians to respect and create space for the sacred or R/S of their patients. Second, reflective practices may help clinicians disconnect between their stated values and practical engagement. The observed tension between operant and espoused voices opens a space for clinicians to critically reflect on their practice and begin to engage with theological literacy within clinical settings.

Normative voice: Institutional frameworks and professional expectations

The normative voice refers to the formal guidelines, codes of ethics, or institutional norms that shape clinical behaviors, such as the principles and guidelines set forth by the NHS, WHO, APA, etc. These often include explicit comments and indeed clinical commitments to holistic, person-centered care, including spiritual well-being. Yet, clinicians in the research reported a disconnect between these institutional aspirations and their daily experience of clinical work.

Several of the interviewees noted that though there is an ongoing awareness of policy-level encouragement to address spirituality, there is a lack of time, confidence, and training for them to be able to do so effectively. One clinician noted, "The NHS life is really busy, there is not a lot of people to see, lots of waiting lists . . . and you don't always get a chance to make that full picture [of what is going on for a patient]." Another interviewee noted, "It's a systematic issue, organisations have to start talking about it and not be afraid of the subject." While a third clinician commented that the interview made them aware of

> the lack of training [on R/S], to be honest, there is mandatory training when you join the NHS. And I mean, that's obviously for all NHS professionals around, like, you know, resuscitation, training and health and safety and prevention training and lots of stuff focused on equality, diversity, inclusion. But I don't actually think there's any particular training about how to have conversations around religion.

This illustrates how espoused institutional beliefs can be undermined and left unfulfilled due to practical constraints, leading to ambivalence or silence regarding R/S experiences.

More subtly, institutions often promote a fragmented model of personhood, where patients are viewed primarily through biomedical or risk-based frameworks, with spiritual dimensions treated as secondary or even irrelevant. This undermines the possibility of a genuinely holistic encounter and highlights how the normative voice, even when well-intentioned, may fail to equip clinicians for integrative care.

Formal theological voice: A reframing tool

The voice of formal theology offers a critical and constructive lens for reimaging how clinicians may better engage with patients' R/S experiences. Rather than asking just *how* clinicians interpret these experiences, a formal theological voice prompts for deeper reflection and asks: What are the embodied, contextual, and lived religious experiences for these patients? What does this tell us about how we understand personhood and human flourishing? Finally, how can examining clinicians' beliefs in this way inform further theological interpretation of R/S experiences and promote genuinely holistic and practical implications for clinical practice and care?

Practical theology is a reflective discipline that calls for ongoing critical and theological reflection upon human experiences to illuminate areas in which we fall short and how to transform experiences to facilitate faithful practices in Christian communities (Swinton & Mowat, 2016). When applied as a lens through which to examine clinical practice, practical theology encourages clinicians to move beyond reductionist or pathologizing models of care that can contribute to epistemic injustice. Instead, it invites deeper engagement with the R/S dimensions of the person's experience, recognizing these as potentially meaningful engagements with identity, human flourishing, lament, suffering, hope, and a connection to the transcendent.

This perspective is particularly important when patients either share their R/S experiences in the context of mental distress or when such experiences may resemble psychiatric symptoms, such as in the case of psychosis. While it is important not to dismiss the clinical reality of symptoms that may have religious content, it is equally important to resist collapsing all spiritual language into pathology. A purely diagnostic interpretation can obscure the personal, existential, and even spiritually

significant aspects of these experiences, potentially leaving the individual feeling judged, misunderstood, or spiritually invalidated (Dein, 2010; Mohr et al., 2009; Salem & Foskett, 2009).

Recognizing this complexity does not mean uncritically affirming all religious content as benign or meaningful. Rather, it suggests that clinicians need the tools to discern when and how such experiences might hold constructive significance for the individual. One such tool is religious and theological literacy—a capacity that can support clinicians in helping individuals explore the personal meaning of their experiences without prematurely framing them as symptoms. Encouraging such exploration may foster a sense of coherence and dignity, and support more holistic and ethically grounded clinical care.

Utilizing a hermeneutic of generosity and thick descriptions (Swinton, 2001, 2020)—an interpretative stance that takes spiritual and religious meaning seriously before immediately ascribing biomedical or biological categories to experiences may create an encouraging shift toward engaging with patients' R/S experiences. Moreover, Swinton (2011) advocates for the practice of "slow listening," a deeply theological act of presence alongside an individual, which may help clinicians resit the urgency to categorize, classify, and medicalize these experiences before exploring the content and significance for the patient. Reframing R/S experiences not necessarily as primary signs of disorder or illness, but as rich sites of meaning that can often reflect a person's connection to the sacred, may help clinicians to better understand these experiences through a lens of critical realism. This means, they do not have to agree that they also see an angel, or that they think this encounter to be a genuine form of communication from the transcendent or divine. Rather, it invites them to recognize the experience as real for the patient and as a significant event which has shaped them going forward.

Perhaps a way forward when it comes to thinking of this is helping the clinician to not think "is this belief a symptom?" and if so, what is it a symptom of? But rather, that by engaging in deep listening and theological literacy, the clinician may be able to ask "What does this belief and experience mean to the person, how does it relate to their understanding of self, suffering, healing and their identity?" (Cook et al., 2009).

This reframing also allows critical engagement with the dominant epistemologies that shape clinical training and discourse. Formal theology challenges the boundaries of what counts as legitimate knowledge, expanding them to include narrative, experience, and relational meaning (Cook, 2013; Swinton, 2020). For clinicians, even a basic theological literacy can enhance cultural humility and spiritual sensitivity, enabling more respectful, curious, and compassionate care (Salem & Foskett, 2009).

In sum, formal theology does not offer clinicians a prescriptive tool, but a reflective and reframing one. It opens space for questioning, for attending to the sacred in the clinical encounter and for resisting the marginalization of religious experience as "other." As such, without space for this form of reflection, R/S experiences risk being misinterpreted, dismissed, or even silenced—not because they lack value, but because the tools to understand them are absent from the clinical imagination.

Limitations

This study was based on a small sample of eight UK-based clinicians, which limits the generalizability of the findings. While the sample was diverse in terms of ethnicity, professional background, and religious affiliation, it may not fully capture the breadth of interpretive frameworks used by clinicians in other contexts or healthcare systems. The qualitative nature of the study and its focus on depth rather than breadth mean that the findings are intended to be illustrative rather than representative. In addition, all interviews were conducted by a single researcher, which may introduce interpretive bias despite efforts to ensure reflexivity and peer debriefing. Future research with larger and more varied samples could help to further validate and expand upon these findings.

Conclusion

This study emphasizes the importance of attending to clinicians' epistemologies and contexts, as these influences how R/S experiences are interpreted in practice. In addition, it is crucial to explore R/S experiences more broadly and to understand how clinicians perceive them. Utilizing practical theology and other interdisciplinary approaches offers a new perspective for investigating these experiences and encourages clinicians to reflect on their practice. Consequently, more nuanced, interdisciplinary, and high-quality research in this field will not only enhance our understanding and provide resources for clinicians to address R/S experiences but also improve patient care.

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