

Clinical Pastoral Counseling to Educate Relatives of Individuals With Psychosis

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Abstract

This article examines clinical pastoral counselling as a means of educating relatives of individuals with psychosis. Psychosis is a mental condition that affects a person's thinking, emotions, and perception of reality, often resulting in hallucinations and delusions. The paper discusses the concept of psychosis, biblical perspectives on mental illness, and the importance of counselling support for affected families. The study employs a qualitative, descriptive methodology through the review of books, scholarly journals, biblical texts, and pastoral counselling materials. Analytical and interpretative methods were used to examine the role of pastoral counselling in family education and support. The study reveals that relatives of individuals with psychosis often face stigma, fear, emotional stress, and a lack of understanding about the condition. Clinical pastoral counselling helps families through spiritual guidance, emotional support, education, and encouragement. The article concludes that pastors, counsellors, and healthcare professionals should collaborate in promoting holistic care for individuals with psychosis. It recommends increased mental health awareness and counselling training within churches and Christian communities.

Keywords: *Psychosis, Clinical Pastoral Counselling, Mental Health, Relatives of Individuals.*

Introduction

In West African society, psychosis is often interpreted through spiritual frameworks, though it is clinically defined within psychosis as a disorder affecting perception, thought, and reality. These disturbances cause significant emotional and existential distress, requiring comprehensive care. Scholars in Medical Anthropology note the coexistence of cultural and biomedical explanations. However, mental health systems often neglect the spiritual dimension of care. This creates a gap, especially in contexts where religion shapes meaning and coping. Insights from Pastoral Theology highlight the importance of faith-informed care. Clinical Pastoral Education (CPE) offers a framework for integrating psychological and spiritual support. It equips caregivers with reflective, empathetic, and spiritually sensitive skills. Such integration promotes assessment, psychoeducation, rehabilitation, and family support. It also enhances meaning-making, trust, and hope in the healing process. Despite its potential, CPE remains underexplored in psychosis care within West Africa. This study evaluates its role in improving psycho-spiritual outcomes and holistic well-being. In most Ghanaian and wider

West African districts, no formal referral channel links church-based pastoral care with district mental health units, so relatives often default to whichever system they encounter first rather than drawing on both in sequence. This study specifically sought to examine the biblical and theological grounding for pastoral engagement with psychosis, assess the educational needs of relatives caring for affected individuals, and propose a framework for integrating pastoral counselling into existing mental health service delivery.

Concept of Psychosis

Psychosis is a cluster of symptoms associated with severe mental health conditions, characterised by a significant impairment in reality testing. Within Psychiatry, it is not classified as a standalone disorder but rather as a syndrome that occurs across a range of conditions, particularly schizophrenia spectrum disorders, bipolar disorder, and major depressive disorder with psychotic features (American Psychiatric Association, 2013,87). It involves a loss of contact with reality, affecting how individuals think, perceive, and interpret their environment. The American Psychological Association defines psychosis as “an abnormal mental state involving significant problems with reality testing” (American Psychological Association, 2025). Individuals experiencing psychosis may have difficulty distinguishing between internal experiences and external reality, often presenting with symptoms such as hallucinations, delusions, and disorganised thinking. These disturbances significantly affect cognitive, emotional, and behavioural functioning. According to the National Institute of Mental Health (2020,2), “psychosis commonly emerges in late adolescence or early adulthood and represents a major mental health concern. During psychotic episodes, individuals may struggle to understand what is real, leading to confusion, distress, and impaired social and occupational functioning.” Similarly, the National Alliance on Mental Illness emphasises that “psychosis is a symptom of underlying mental illness rather than a disorder in itself” (NAMI, 2020,3). Research of the Australian Government Department of Health and Ageing (2025,2) emphasises that Psychosis can arise from multiple causes, including primary psychiatric conditions, substance use, and medical or neurological disorders.” For clinical clarity, it is commonly classified into primary psychotic disorders (such as schizophrenia and brief psychotic disorder), mood disorders with psychotic features (such as bipolar disorder and major depressive disorder), substance-induced psychosis, and psychosis due to medical conditions. This classification is essential for accurate diagnosis, treatment planning, and effective psychoeducation.

Signs and Symptoms of Psychosis

There are numerous signs and symptoms of psychosis; these symptoms can be thinking, perception, emotions, and behaviour, often resulting in significant impairment in daily functioning. Understanding these features helps pastoral caregivers and counsellors provide appropriate support. Delusions are persistent, firmly held false beliefs that persist despite clear and logical evidence to the contrary. Individuals experiencing psychosis may believe that others are plotting against them, monitoring their actions, or trying to harm them in some way. American Psychological Association (2018,2) and Cooke (2017,7) stated that “in some cases, they may also believe they possess special powers, identities, or messages meant only for them.” These beliefs are often resistant to reasoning and can significantly influence behaviour and decision-making. As a result, delusions can interfere with relationships, trust, and the ability to function normally in society. Hallucinations refer to sensory perceptions that occur in the absence of external stimuli, meaning the individual sees, hears, or feels things that are not actually present. Auditory hallucinations are the most common form, often involving voices that may comment on the person’s behaviour, criticise them, or give commands (Bromley et al., 2015; NAMI Minnesota, 2020). These voices can be distressing and may influence the

individual's actions in harmful ways. Visual, tactile, or olfactory hallucinations may also occur, though less frequently. Such experiences can make it difficult for individuals to distinguish between reality and imagination, thereby increasing confusion and fear.

Suspicion and paranoia involve an exaggerated sense of mistrust or fear of others, even in the absence of real threats. Individuals may feel constantly watched, judged, or targeted, which can lead to withdrawal from social interactions (Mind, 2025,5). This heightened sense of danger often causes anxiety and defensive behaviour, making it difficult to maintain relationships or engage in normal activities. Paranoia can also escalate into severe fear, where the individual avoids people or places they believe are unsafe. Over time, this can contribute to isolation and worsen the overall condition. Disorganised thinking is one of the key features of psychosis and reflects a breakdown in the ability to process information logically. Individuals may struggle to concentrate, follow conversations, or organise their thoughts in a meaningful way. Their thinking may become fragmented or illogical, leading to confusion and difficulty in making decisions (Broome et al., 2005, 11). This psychosis can affect academic, professional, and social functioning. As the condition progresses, it may become increasingly difficult for the individual to perform even simple mental tasks. Disorganised thinking often manifests in speech, making communication difficult and sometimes incoherent. Individuals may jump from one topic to another without a logical connection, use unrelated words, or create sentences that are hard to understand (Brown and Bagley, 2012, 10). In severe cases, speech may become completely disjointed, a condition sometimes called "word salad." This disruption in communication can hinder effective interaction with others and may lead to frustration or misunderstanding. It also serves as an important clinical indicator of underlying cognitive disturbance. Psychosis often involves significant changes in emotional expression and regulation (Jarvis, 2007, cf Nature Mental Health, 2025). Individuals may experience intense anxiety, mood swings, or inappropriate emotional responses that do not match the situation. In contrast, some individuals may exhibit a reduced range of emotions, known as flat affect, appearing emotionally unresponsive. These emotional disturbances can affect interpersonal relationships and reduce the individual's ability to cope with stress. Over time, this may contribute to social withdrawal and decreased quality of life. Individuals with psychosis frequently report strange or exaggerated ideas that are difficult for others to understand. These may include distorted perceptions of reality, unusual beliefs about the world, or a sense of detachment from one's environment or self. Such experiences can be confusing and frightening, leading to increased distress. The individual may struggle to interpret events accurately, often assigning incorrect or exaggerated meanings to ordinary situations (Parnas et al., 2010,37). This distortion further contributes to impaired judgment and behaviour.

A noticeable decline in personal hygiene and self-care is commonly observed in individuals with psychosis. Activities such as bathing, dressing appropriately, and maintaining cleanliness may be neglected (Kreider and Sivec, 2020,9). This decline is often linked to reduced motivation, disorganised thinking, or a lack of awareness of one's condition. Poor self-care can negatively impact physical health and social acceptance, further isolating the individual. It also serves as an important warning sign for caregivers and professionals to intervene early.

Sleep problems are frequently associated with psychosis and may include difficulty falling asleep, staying asleep, or experiencing significantly reduced sleep duration. In some cases, individuals may stay awake for extended periods without feeling tired. Lack of proper sleep can worsen other symptoms such as hallucinations, confusion, and emotional instability (Australian Government Department of Health and Ageing, 2025,8). Sleep disturbances may also serve as an early indicator of an impending psychotic episode. Addressing sleep issues is therefore an important aspect of treatment and management. Impaired reality testing refers to the inability to distinguish between what is real and what is imagined. Individuals may firmly believe in experiences or perceptions that have no basis in reality. This impairment affects

judgment, decision-making, and behaviour, often leading to actions that others find irrational. It is a central feature of psychosis and contributes significantly to the challenges faced by affected individuals (American Psychiatric Association, 2022,5). Without intervention, this symptom can severely disrupt daily functioning. Psychosis often leads to a noticeable decline in an individual's ability to function in everyday life. This may include poor academic performance, reduced productivity at work, or inability to manage daily responsibilities. Individuals may withdraw from social activities and lose interest in previously meaningful pursuits (McCarthy and Karmacharya, 2024). This decline is usually gradual but can become severe if left untreated. Early intervention is crucial to prevent long-term impairment and to support recovery. A lack of motivation, also known as avolition, is a common symptom of psychosis. Individuals may struggle to initiate or complete tasks, even simple ones or those that were previously enjoyable. This can affect personal, social, and occupational functioning. The individual may appear lazy or uninterested, but this symptom stems from psychological and neurological changes. Over time, reduced motivation can lead to inactivity, dependency, and further deterioration in mental health.

Causes of Psychosis

Psychosis is a complex mental condition characterised by a loss of contact with reality, and its causes are multifactorial, involving biological, psychological, and social factors. Research shows that several things can cause or influence the onset of psychosis. These things can be grouped into six factors: situation, physical state, thoughts, perceptions, emotions, and actions. Genetic and Hereditary Factors: Research Anne Cooke (2017,3) shows that "family history, such as schizophrenia, is at a higher risk of developing psychosis." Genetic vulnerability does not directly cause psychosis but creates a predisposition that environmental factors may activate. According to Calabrese and Al Khalili (2023), "there is significant evidence for genetic risk factors in the pathogenesis of psychotic disorders." This implies that family genetics plays a foundational role, particularly in disorders such as schizophrenia, where heredity significantly influences susceptibility.

Neurobiological and Brain Chemical Imbalance: The most widely accepted biological explanation of brain chemical imbalances is the dopamine hypothesis, which suggests that excessive dopamine activity in certain brain pathways leads to psychotic symptoms such as hallucinations and delusions (Josef Parnas, Julie Nordgaard, and Somogy Varga 2010, 6). Scientific and psychological studies indicate that psychosis is associated with increased dopamine activity, dysfunction in glutamate systems, and imbalance in GABA and acetylcholine. These neurochemical abnormalities disrupt normal perception and thinking, leading to distorted interpretations of reality. Brain imaging studies have also shown structural changes, such as reduced grey matter in specific brain regions, in individuals experiencing psychosis. Substance Abuse and Drug Use: The use of cannabis or marijuana, alcohol and other illegal drugs such as amphetamine, cocaine, methamphetamine, mephedrone, MDMA or ecstasy, LSD or acid, psilocybin or mushrooms, ketamine, and opiates or heroin (Australian Government Department of Health and Ageing, 2025, 4). Research of Alison (2020,8) shows that "substance-induced psychosis may occur either: During intoxication, During withdrawal, As a long-term effect of chronic use." Broome et al. (2005,34) further explain that drugs like amphetamines and cannabis can precipitate psychosis by altering dopamine regulation in the brain, leading to misinterpretation of reality." This shows that drug abuse or drug use is one of the major causes of psychosis in contemporary times.

Psychological Trauma and Severe Stress: Experiences such as childhood abuse, neglect, bereavement, or extreme life stress can trigger psychotpsychotic symptoms (Geraldine 2019,4). Evidence shows that chronic conditions can lead to breakdown in mental functioning, trauma can distort perception and cognition, and social adversity increases vulnerability. Stress is

believed to interact with biological vulnerability, leading to the onset of psychosis. For example, a stressful situation affects your physical state. When your physical state changes, your thoughts may change as well (Nature Mental Health Psychosis 2025, 3877). This aligns with the stress vulnerability model, which explains that individuals with underlying susceptibility may develop psychosis when exposed to high levels of stress.

Medical and Neurological Conditions: Psychosis can also arise from underlying medical or neurological disorders. Kreider and Harry (2020,12), highlighted that 'conditions affecting the brain often interfere with perception, cognition, and behaviour.' Examples include: lack of sleep, poor nutrition, brain injuries or tumours, epilepsy, stroke, chromosomal disorders, and brain tumours. **Environmental and Social Factors:** Environmental conditions also influence the development of psychosis, including poverty and social isolation, migration and discrimination, urban living conditions, and lack of sleep or extreme deprivation. Social adversity, including migration and isolation, contributes significantly to psychosis onset (Jarvis, 2007, 291). Additionally, environmental stressors during pregnancy, such as maternal malnutrition or infection, can increase the risk of psychosis later in life. These factors demonstrate that psychosis is not purely biological but is shaped by the social context in which an individual lives.

Effects of Psychosis

Psychosis in West African society represents a serious issue that can be understood through social, religious, cultural, economic, and political lenses.

Social Effects: Individuals who have psychosis in West African communities often experience social withdrawal, isolation, and difficulty maintaining relationships due to symptoms such as hallucinations, delusions, and disorganised thinking. According to Jarvis (2007, 291), "these symptoms reduce their ability to communicate effectively and participate in normal social interactions." Research by Westhead and Georgiades (2025,17) shows that "people with psychosis frequently experience reduced social inclusion and increased marginalisation in society." Social stigma also plays a major role, as individuals are often misunderstood, feared, or discriminated against, which further deepens their isolation. In West African society, family relationships may also be strained due to caregiving burdens, emotional stress, and misunderstanding of the illness. In many cases, lack of social support worsens the condition and delays recovery. **Religious Effects:** Many individuals in West African communities with psychosis experience religious delusions, such as believing they have divine powers, are chosen by God, or are being punished spiritually. Sofou and Konstantakopoulos (2021,228), mention that "religious beliefs can influence how psychosis is interpreted." In Ghana, for instance, symptoms are attributed to spiritual causes such as witchcraft, curse, demonic possession, superstition, or divine punishment rather than medical conditions. This sometimes creates a delay in appropriate treatment as individuals may seek only spiritual interventions. A practical discernment step can help pastors decide whether to pray, refer, or both: whether the onset was sudden and tied to substance use or sleep loss, whether the content of a perceived revelation is consistent with sound doctrine, and whether the person poses a danger to self or others (Sofou, Giannakopoulos, Arampatzi, and Konstantakopoulos, 2021).

Cultural Effects: Cultural beliefs influence the content of hallucinations and delusions, often reflecting local traditions, values, superstitions, and fears. In many societies, especially West African societies, psychosis may be interpreted through cultural frameworks such as ancestral spirits, curses, or supernatural forces. Wong and Howie (2020,124) present that "culture perception or interpretations affect help-seeking behaviour, often leading individuals to traditional healers instead of medical professionals." Cultural stigma is another major issue in West Africa. In some West African communities, mental illness is associated with shame, leading to secrecy, discrimination, rejection, or exclusion from community members. This

cultural perception can hinder early diagnosis, assessment and treatment. **Economic Effects:** Psychosis has significant economic consequences for individuals, families, and society. Individuals with psychosis often experience reduced productivity, unemployment, or an inability to maintain stable work due to cognitive impairment and functional limitations. The cost of treatment, including medication, hospitalisation, and long-term care, places a financial strain on families (Jarvis, 2007, 273). In West Africa, psychosis contributes to economic burden through healthcare costs, loss of workforce participation, and social welfare dependence. Additionally, social disadvantage and poverty are closely linked to psychosis, creating a cycle where economic hardship increases vulnerability to mental illness and vice versa. In Ghana specifically, the National Health Insurance Scheme offers thin coverage for sustained psychiatric and psychosocial care, which pushes much of the cost of relapse and hospitalisation back onto families and further underscores the value of lower-cost, church-based psychoeducation. **Political Effects:** Psychosis also has subtle but important political implications. The content of delusions is often influenced by West African political environments, including themes of persecution, surveillance, or government control. On a broader level, psychosis raises important issues for public policy, such as: Mental health legislation and human rights, Access to mental health services, Social inclusion policies, Protection against discrimination, and Governments play a critical role in providing mental health infrastructure, funding, and awareness programs (Menezes and Almeida, 2010,173). Poor political commitment to mental health often results in inadequate care systems, especially in Ghana. Additionally, individuals with psychosis may be excluded from political participation due to stigma, cognitive challenges, or institutional barriers, limiting their civic engagement and representation. National mental health policy revisions should formally recognise faith leaders as community-level partners rather than leaving their involvement informal, since much of the day-to-day support relatives receive already passes through churches rather than clinics.

Biblical View on Psychosis

Although the Bible does not explicitly use the term “psychosis,” it offers principles that guide understanding of abnormal thoughts, perceptions, and behaviours within a holistic view of the human person. From a biblical perspective, human beings are created in the image of God (Genesis 1:27), which affirms the inherent dignity and worth of every individual, including those experiencing mental illness or psychological problems. The Bible presents humans as integrated beings, body, mind, and spirit, suggesting that disturbances in mental functioning are not isolated from the total person. Psychosis may therefore be understood as a disruption in the mind that is part of the broader brokenness of human existence following the Fall (Genesis 3). However, Scripture cautions against attributing all suffering to personal sin. In John 9:1–3, Jesus rejects the assumption that a man’s condition is the result of sin, indicating that illness, including mental illness, can occur without direct moral causation. Because the image of God does not depend on cognitive or perceptual function, a person’s psychotic symptoms cannot diminish their standing before God or their community. This gives the pastoral counsellor a theological basis for actively countering stigma rather than merely tolerating the person affected. Biblical narratives also describe individuals whose behaviours resemble symptoms associated with psychosis. King Saul, for example, experienced emotional instability, paranoia, and distress (1 Samuel 16:14–23), while King Nebuchadnezzar underwent a period of extreme behavioural disturbance, living like an animal (Daniel 4:33). These accounts demonstrate that severe mental disturbances were recognised in biblical times. Additionally, some New Testament passages, such as Mark 5:1–15, describe cases interpreted as demonic possession. While these texts indicate a spiritual dimension in certain situations, the Bible does not uniformly equate all abnormal behaviour with demonic activity, thereby

allowing for a broader and more nuanced understanding. The call to “bear one another’s burdens” (Galatians 6:2) includes caring for those with mental illness through prayer, encouragement, and practical assistance. Engaging professional mental health services is not contrary to faith but can be seen as part of God’s common grace, providing means for healing and restoration. The biblical and theological view of psychosis recognises it as part of the broader reality of suffering in a fallen world. It affirms the dignity of those affected, rejects simplistic explanations, and promotes a compassionate, holistic approach that integrates spiritual care with medical and psychological support. Ultimately, it offers hope grounded in God’s presence and the promise of restoration. These narrative accounts, however, should not be treated as ancient diagnostic labels for schizophrenia or psychosis. They are narrative theology making a point about divine sovereignty and judgement, not clinical case notes, and pastors who collapse the two risk both poor theology and poor pastoral care.

Clinical Education Counselling For Individuals With Psychosis

Clinical counselling education plays a critical role in managing psychosis. Clinical counselling education involves structured therapeutic interventions designed to educate individuals, improve coping mechanisms, enhance insight, and promote recovery from any form of mental illness. Unlike purely medical approaches, counselling focuses on psychological, social, and behavioural dimensions of the illness, making it essential for long-term rehabilitation. Therefore, the person who has psychosis needs to seek counselling as early as possible. However, in the early stages of psychosis, people often do not know what is happening to them and do not seek treatment right away. Some people may feel there is nothing wrong or that symptoms will go away on their own. Others, if they are aware of the problem, may have concerns about the required counselling. **Assessment:** Before taking steps to specific counselling or treatment, a person with psychosis, a counsellor should conduct a thorough assessment, which can include educational counsellors, medical counsellors, psychiatrists, psychologists, psychiatric nurses, occupational therapists, and social workers, as well as hospital chaplains or pastoral care coordinators (Bromley, Choi, and Faruqui 2015, 12, cf. Anne Cooke 2017, 8). Through assessment, areas such as mental status examination (mse), risk assessment, psychiatric history, medical and neurological evaluation (such as assessments for brain injury and infections), substance use evaluation (including drug-induced psychosis), cognitive assessment, substance use assessment, psychosocial evaluation, consideration of cultural and religious factors, analysis of psychopathology, functional assessment, utilisation of standardised assessment tools, and collection of collateral information. The information gathered from the assessment will help the counsellor determine the type of psychosis the person is experiencing, its possible causes, and the best way of helping the person.

Psychoeducation: Psychoeducation is one of the most essential components of educational clinical counselling for psychosis. Srivastava and Panday (2016, 1244) cited Bauml and Pitschel-Walz (2008) on psychoeducation, which involves systematically teaching patients and their families about the nature of the illness, its causes, symptoms, treatment options, and prognosis. This approach reduces confusion and fear often associated with psychosis experiences. Individuals begin to understand that symptoms rather than reality are the warning signs, and that strategies for relapse prevention, stress management techniques, and improved communication skills help reduce distress. Psychoeducation also improves medication adherence by helping patients recognise the importance of pharmacological treatment.

Rehabilitation: Individuals with psychosis often experience deficits in social and occupational functioning. Training structured counselling approach that helps individuals relearn essential interpersonal skills, including verbal and nonverbal communication, assertiveness, conflict resolution, and relationship-building. Rehabilitation counselling extends beyond social skills to include vocational and daily living skills. Patients are trained in job-readiness and workplace

behaviour, time management and organisation, personal hygiene and self-care, and independent living skills. National Institute for Health and Care Excellence (2014,145), “psychosocial interventions significantly improve functional outcomes when combined with medication.” These interventions are particularly effective in addressing negative symptoms such as social withdrawal, apathy, and lack of motivation. Many West African churches already run apprenticeship, microenterprise, or welfare programmes that could formally receive rehabilitation referrals, giving discharged patients a structured, faith-community-based path back into daily and working life rather than leaving reintegration informal.

Family Education Counselling: Families play a vital role in clinical counselling education intervention for psychosis. Since many individuals with psychosis live with family members, the home environment plays a crucial role in recovery. Lucksted et al. (2012, pp. 103–110) highlight that family counselling helps reduce these negative dynamics and hospitalisation rates and improve long-term outcomes. This shows that family counselling interventions are intended to educate family members, improve communication patterns, reduce conflict, stigma, discrimination, criticism, and hostility, provide psychological and emotional support, and encourage treatment adherence. Structuring this family education as a defined curriculum, a fixed number of sessions with stated learning objectives, and a built-in referral loop back to clinical services if a relative reports relapse warning signs, would give the intervention the same operational clarity it already has in principle.

Guiding: Clinical educational counselling and mental health care emphasise a guidance recovery-oriented approach that helps individuals live meaningful lives despite ongoing symptoms. Recovery is not defined as complete symptom elimination but as the ability to function, find purpose, guidance, and maintain hope. Guidance counselling interventions in this model include goal setting and personal development, encouragement, strength-based approaches, empowerment and self-advocacy, and identity reconstruction. Hutton and Taylor (2014,452) opine that “counselling strategies at this stage include early detection and assessment, psychoeducation and monitoring, cognitive therapy to challenge emerging delusions, and stress reduction techniques. This implies that early intervention services also improve long-term prognosis and reduce the severity of the disorder. Because pastoral counsellors often meet families before any clinician does, they are well placed to serve as an early triage point themselves, provided they are trained to recognise red-flag symptoms and refer promptly rather than only monitor.

Ethical Care: The therapeutic relationship between counsellor and client is a critical factor in successful treatment outcomes. Individuals with psychosis may experience paranoia or mistrust, making it essential for counsellors to establish trust and rapport. Montesano (2012,260) emphasises that a strong ethical alliance improves engagement and treatment adherence in individuals with psychosis. This means counselling of individuals with psychosis requires balancing autonomy, safety, and professional responsibility. Counsellors must remain sensitive, competent, and vigilant while providing compassionate, evidence-based care. Ethical practice is not static but requires continuous reflection, supervision, and adherence to professional guidelines. In practice, this means pastoral counsellors handling family disclosures about psychosis should work under the same confidentiality standards and case-supervision arrangements that clinical counsellors follow, since informal church-based counselling often lacks either.

Medication Education: The counsellor should educate people that medication is helpful alongside counselling. The American Psychological Association Dictionary (2025,12) explains that “medications help manage and treat psychosis and also play a critical role in preventing further episodes of illness.” According to McCarthy and Karmacharya (2024,37), these “medications are generally divided into two categories: typical (first-generation) antipsychotics and the newer atypical (second-generation) antipsychotics.” Counsellors should encourage individuals experiencing psychosis to seek appropriate medical evaluation and treatment. An educational counselling medication approach reflects responsible practice, ensuring the client receives

comprehensive, evidence-based treatment. Church small groups or accountability partners can also play a quiet but real role in adherence follow-up between clinical visits, noticing missed doses, relapse warning signs, or side-effect complaints that might otherwise go unreported until the next appointment.

Conclusion and Recommendation

Integrating Clinical Pastoral Education into counselling individuals with psychosis provides a comprehensive framework that attends to both mental health needs and spiritual concerns. It enhances the counsellor's ability to offer compassionate, ethical, and person-centred care while supporting recovery and meaning-making. This approach fosters collaboration between clinical and pastoral disciplines, ultimately improving the quality of care and promoting holistic healing for individuals experiencing psychosis. Based on the research, the following recommendations are made:

- i. Incorporate Clinical Pastoral Education (CPE) training into counselling curricula to equip practitioners with spiritual care competencies.
- ii. Promote interdisciplinary collaboration between mental health professionals and pastoral caregivers.
- iii. Establish formal referral agreements (memoranda of understanding) between health facilities and churches that define pathways in both directions.
- iv. Track simple outcome indicators for Clinical Pastoral Education-based family programmes, such as relapse rate, caregiver stress, and time to treatment, to ensure holistic care remains measurable.
- v. Position pastoral counsellors as a competent first point of contact who refers onward for psychiatric care, rather than a substitute for it.

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