Development and Validation of the Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS): A Biopsychosociotechno-Spiritual Screening Instrument for Schizophrenia Spectrum and Bipolar Disorders

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ABSTRACT

Background: Severe mental illnesses, particularly schizophrenia spectrum and bipolar disorders, are frequently interpreted through spiritual and religious frameworks, especially within culturally and religiously embedded contexts. While spiritual meaning-making can be adaptive, rigid spiritual or diabolical attributions may delay help-seeking, intensify distress, and increase clinical risk. Existing psychiatric screening instruments rarely assess these attributional processes alongside symptom presentation.

Objective: This study aimed to develop and provide preliminary psychometric evidence for the Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS), a multidimensional screening instrument designed to identify indicators of schizophrenia spectrum and bipolar disorders while concurrently assessing spiritual distress and spiritual–demonic attribution.

Methods: The study employed a cross-sectional instrument development and preliminary validation design grounded in Psycho-Spiritual Therapy and the Biopsychosociotechno-Spiritual framework. The Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS) was developed to assess clinical symptoms alongside psychospiritual attributional processes. Internal consistency reliability of the total scale and its subscales was evaluated using Cronbach's alpha coefficients.

Results: The PS-SMHIS demonstrated good to excellent internal consistency across domains, with Cronbach's alpha values ranging from .773 to .915. Excellent reliability was observed for the Schizophrenia Spectrum and Mania indices, acceptable reliability for the Hypomania index, and good reliability for the Depression, Spiritual Distress, and Spiritual–Diabolic Attribution indices. These findings indicate strong internal coherence across both clinical and psychospiritual constructs.

Conclusion: The PS-SMHIS shows promising preliminary reliability as a psychometrically sound, multidimensional screening instrument. By distinguishing psychiatric symptoms from spiritual distress and attributional risk, the scale supports ethical discernment, early identification, and appropriate referral. Further large-scale, cross-cultural validation studies are recommended to strengthen its clinical and pastoral applicability.

Keywords: psycho-spiritual assessment; schizophrenia; bipolar disorder; spiritual attribution; mental health screening; biopsychosociotechno-spiritual

INTRODUCTION

Severe mental illnesses (SMI) are rarely experienced or interpreted in purely biomedical terms. Across diverse cultural contexts, psychological distress is frequently understood through spiritual, religious, and existential narratives (Pargament & Lomax, 2013). In schizophrenia spectrum and bipolar disorders, symptoms such as hallucinations, delusions, and mood disturbances are often interpreted as spiritual attacks, demonic influence, or divine calling (Cook, 2015).

While spiritual meaning-making can be adaptive, the misattribution of psychiatric symptoms to spiritual causation often delays evidence-based treatment and intensifies patient suffering (Koenig, 2015). Existing psychiatric screening tools, such as the *Positive and Negative Syndrome Scale (PANSS)*, prioritize symptom detection but rarely assess the individual's spiritual interpretation of those symptoms. Conversely, pastoral assessments often lack the clinical safeguards necessary to identify underlying psychopathology. The PS-SMHIS bridges this gap by integrating clinical symptom screening with psycho-spiritual discernment.

Objective of the Study

The primary objective of this study was to develop and provide preliminary psychometric evidence for the Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS), a multidimensional screening instrument designed to identify indicators of schizophrenia spectrum and bipolar disorders while simultaneously assessing spiritual distress and spiritual-diabolic attribution.

Specifically, the study aimed to:

1. Operationalize clinical and psychospiritual constructs within a unified biopsychosociotechno-spiritual framework;

2. Examine the internal consistency reliability of the PS-SMHIS total scale and its constituent indices, and

3. Establish the scale's utility as an ethical screening and discernment tool, capable of distinguishing psychiatric symptomatology from spiritual distress and maladaptive attributional patterns, thereby supporting early identification, appropriate referral, and integrative clinical psycho-spiritual care.

METHODOLOGY

Study Design

This study adopted a cross-sectional instrument development and preliminary validation design to evaluate the internal consistency reliability of the Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS). The PS-SMHIS was explicitly developed as a screening and discernment instrument rather than a diagnostic tool, with the primary aim of supporting early identification, ethical referral, and integrative decision-making within clinical and psycho-spiritual care contexts.

Theoretical Framework

The development of the PS-SMHIS was informed by Psycho-Spiritual Therapy (Egunjobi, 2024/2025) and the Biopsychosociotechno-Spiritual (BPSTS) Model (2024/2025/2026), which conceptualizes severe mental illness as a multidimensional phenomenon involving biological, psychological, social, technological, and spiritual domains. Within this framework, spiritual and diabolical constructs were operationalized as attributional and phenomenological variables, rather than ontological realities. This approach allowed for ethical assessment of spiritual interpretations without affirming supernatural causation, thereby maintaining clinical responsibility while respecting culturally embedded belief systems.

Item Development and Content Mapping

Item generation followed a theory-driven, construct-mapped process. Core symptom domains were identified through systematic mapping of DSM-5-TR diagnostic criteria for schizophrenia spectrum and bipolar disorders onto psychospiritual constructs, including existential disorientation, spiritual distress, and rigid spiritual–diabolical attribution.

An initial pool of items underwent iterative review to ensure conceptual clarity, cultural and spiritual sensitivity, clinical relevance, and ethical non-affirmation of delusional content. Items were carefully refined so that spiritual language assessed meaning-making and attributional style rather than the validity of beliefs themselves, thereby minimizing the risk of reinforcing psychopathology.

Scale Structure

The finalized PS-SMHIS comprises 41 items organized into seven sections, yielding six distinct indices: Schizophrenia Spectrum, Mania, Hypomania, Depression, Spiritual Distress, and Spiritual–Diabolic Attribution. This modular structure enables clinicians and psycho-spiritual practitioners to differentiate psychotic symptoms from mood dysregulation, spiritual distress from psychiatric pathology, and adaptive spiritual coping from attributional risk.

Table 1 Domains of PS-SMHIS

Section	Domain Focus	Clinical Correlation
A	Reality Perception	Positive Symptoms (Schizophrenia)
B	Emotional/Social Withdrawal	Negative Symptoms (Schizophrenia)
C	Manic Activation	Bipolar I
D	Hypomanic Activation	Bipolar II
E	Depressive Deactivation	Bipolar I & II Depression
F	Existential Disorientation	Spiritual Distress
G	Diabolical Attribution	Risk of "Spiritual Bypass"

Participants and Sampling

Participants were recruited from educational, religious, and psycho-spiritual settings, reflecting a population in which spiritual interpretation of distress is both salient and clinically relevant. This sampling strategy was considered appropriate for the initial validation of a psychospiritual screening instrument. Demographic information collected included age, gender, socioeconomic status, and occupation.

Procedure

Administration of the PS-SMHIS was conducted in a supervised setting, with completion times ranging between 20 and 25 minutes. Ethical safeguards were emphasized throughout the process, including informed consent and explicit clarification that the instrument does not diagnose mental illness nor validate spiritual or diabolical causation. These safeguards were implemented to protect participants and to reinforce the scale's intended role as an aid to discernment and referral.

Data Analysis

Internal consistency reliability was evaluated using Cronbach's alpha coefficients for the total scale and each subscale. In addition, split-half reliability and Spearman–Brown coefficients were calculated to further assess internal coherence. Reliability benchmarks followed conventional psychometric standards, with alpha values of 0.70 or higher considered acceptable for early-stage instrument development.

FINDING

This section reports the findings of the study, including the demographic profile of participants and the internal consistency reliability of the PS-SMHIS and its subscales.

Demography

This section outlines the demographic profile of the participants, providing contextual background for the interpretation of the study's findings.

Table 2 Demography

		Frequency	Percent
Age	16-20	15	11.4
	21-30	24	18.2
	31-40	18	13.6
	41+	75	58.8
Gender	Female	86	65.2
	Male	46	34.8
Socioeconomic	Very Poor	1	0.8
	Poor	14	10.6
	Middle Class	107	81.1
	Wealthy	9	6.8
	Very Wealthy	1	0.8
Occupation	Student	43	32.6
	Professional	29	22.0
	Administration	7	5.3
	Skilled Trader	3	2.3
	Specialists	2	1.5
	Religious	48	36.4

As shown in Table 2, the study sample reflects a gender-mixed population with stronger female representation, suggesting that the preliminary psychometric findings are informed by perspectives from both sexes, though with a slight gender imbalance. The age distribution indicates that the instrument was primarily administered among adult and mature participants, a factor that may influence patterns of symptom awareness, help-seeking behavior, and spiritual meaning-making captured by the scale.

The sample was largely characterized by moderate socioeconomic stability, which may have facilitated access to educational, clinical, and spiritual resources relevant to psycho-spiritual assessment. Additionally, the occupational profile reveals substantial representation from religious and student populations, a contextual feature that is particularly salient given the psycho-spiritual focus of the PS-SMHIS. This composition suggests that spiritual distress and attributional processes were assessed within a population for whom spirituality is likely to be meaningful and actively integrated into daily life.

Collectively, these demographic characteristics provide an appropriate context for initial scale development while also indicating the need for future validation across more socioeconomically, occupationally, and culturally diverse samples to strengthen the generalizability of the findings.

Summary of the Reliability of the PS-SMHIS and its Domains

The Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS) demonstrates excellent reliability and good to excellent internal consistency across its six domains, indicating that the items within each domain reliably measure a coherent construct.

Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS)

Tables 3 and 4 present the reliability of the PS-SMHIS.

Table 3 Reliability Statistics of PS-SMHIS in Cronbach's Alpha

Cronbach's Alpha	N of Items
.964	41

Table 4 Guttman Split-Half Coefficient of PS-SMHIS

Cronbach's Alpha	Part 1	Value	.926
		N of Items	21[a]
	Part 2	Value	.950
		N of Items	20[b]
	Total N of Items		41
Correlation Between Forms			.801
Spearman-Brown Coefficient	Equal Length		.889
	Unequal Length		.889
Guttman Split-Half Coefficient			.888
a. The items are: SSI1, SSI2, SSI3, SSI4, SSI5, SSI6, SSI7, SSI8, SSI9, SSI10, SSI11, SSI12, MI13, MI14, MI15, MI16, MI17, MI18, MI19, HMI20, HMI21.			
b. The items are: HMI21, HMI22, HMI23, DI24, DI25, DI26, DI27, DI28, SDI29, SDI30, SDI31, SDI32, SDAI33, SDAI34, SDAI35, SDAI36, SDAI37, SDAI38, SDAI39, SDAI40, SDAI41.			

Schizophrenia Spectrum Index (SSI)

Table 5 presents the reliability of the Schizophrenia Spectrum Index (SSI) domain of PS-SMHIS.

Table 5 Reliability Statistics of SSI

Cronbach's Alpha	N of Items
.862	12

This coefficient indicates excellent internal consistency. The high alpha suggests strong inter-item correlation among indicators of reality perception disturbance and thought disorganization. The reliability level is consistent with established clinical instruments used to screen schizophrenia spectrum symptoms. The SSI is a highly reliable domain suitable for clinical screening and research applications.

Mania Index (MI)

Mania Index (MI) domain, as shown in Table 6, shows the reliability statistically measured by Cronbach's Alpha.

Table 6 Reliability Statistics of MI

Cronbach's Alpha	N of Items
.860	7

Table 6 shows an excellent reliability coefficient, exceeding the commonly accepted .90 threshold. Items assessing manic activation, elevated mood, decreased need for sleep, and functional disruption are strongly cohesive. The MI demonstrates robust internal consistency, supporting its use in identifying Bipolar I manic symptom patterns.

Hypomania Index (HMI)

Table 7 Reliability Statistics of HMI

Cronbach's Alpha	**N of Items**
.773	**4**

This coefficient reflects good internal consistency, despite the small number of items. Slightly lower alpha values are expected in brief subscales assessing nuanced constructs such as hypomania. The HMI is sufficiently reliable for screening purposes, though future studies may enhance reliability by refining or expanding item content.

Depression Index (DI)

Table 8 presents the reliability of the Depression Index domain of PS-SMHIS

Table 8

Cronbach's Alpha Reliability Statistics of DI	**N of Items**
.896	**5**

The Depression Index shows good internal consistency. Items coherently assess depressive deactivation, including low mood, anhedonia, fatigue, and hopelessness. The DI reliably captures depressive symptomatology within bipolar and severe mental health contexts.

Spiritual Distress Index (SDI)

The reliability of the domain Spiritual Distress Index of PS-SHMIS is presented in Table 9.

Table 9 Reliability Statistics of SDI

Cronbach's Alpha	**N of Items**
.889	**4**

Table 9 reflects good reliability for a psycho-spiritual construct. The scale demonstrates consistent measurement of existential disorientation, loss of meaning, and spiritual confusion. The SDI shows strong internal coherence, supporting the psychometric legitimacy of spiritual distress as a measurable clinical dimension.

Spiritual-Diabolic Attribution Index (SDAI)

Spiritual–Diabolic Attribution Index's (SDAI) reliability was investigated statistically, and the following was the finding as shown in Table 8.

Table 10 Reliability Statistics of SDAI

Cronbach's Alpha	N of Items
.915	9

This indicates excellent internal consistency. The items consistently measure attributional beliefs, fear, perceived spiritual attack, and avoidance of clinical care. The SDAI is a reliable index for assessing spiritual-diabolic attribution patterns and associated clinical risk.

Internal consistency testing indicated that PS-SMHIS demonstrated excellent reliability, α = .964, and strong reliability in all its domains. Cronbach's alpha values ranged from .773 to .915. Excellent reliability was observed for the Schizophrenia Spectrum Index (α = .862) and the Mania Index (α = .860). The Hypomania Index showed acceptable internal consistency (α = .773), whereas the Depression Index (α = .896), Spiritual Distress Index (α = .889), and Spiritual–Diabolic Attribution Index (α = .915) reflected good reliability. Overall, these results provide robust support for the PS-SMHIS as a psychometrically reliable and multidimensional screening measure.

DISCUSSION

The present study provides preliminary psychometric support for the Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS) as a multidimensional screening instrument integrating psychiatric symptom detection with psycho-spiritual discernment. The findings contribute to a growing body of research emphasizing that spirituality functions as both a protective and risk factor in severe mental illness, depending on attributional rigidity, emotional tone, and symptom severity.

The excellent internal consistency observed for the Schizophrenia Spectrum Index and Mania Index aligns with extensive literature demonstrating the structural coherence of psychotic and manic symptom clusters across cultures. Importantly, the PS-SMHIS demonstrates that psychotic symptoms can be reliably identified without conflating religious or spiritual content with pathology, a distinction increasingly emphasized in contemporary psychiatry and spiritually integrated care.

The Hypomania Index demonstrated acceptable reliability despite its brevity, reflecting known challenges in operationalizing hypomania due to overlap with culturally valued traits such as productivity, creativity, and spiritual enthusiasm. The scale's requirement that hypomanic indicators be interpreted in relation to depressive symptoms represents a clinically conservative and ethically sound approach consistent with dimensional models of bipolar disorder.

The Depression Index showed strong internal consistency, supporting its role as a severity amplifier within the scale. This is particularly relevant given empirical evidence that depressive symptoms often mediate the relationship between spiritual distress, attributional rigidity, and adverse clinical outcomes.

Of particular significance are the findings related to the Spiritual Distress Index and the Spiritual–Diabolic Attribution Index. The strong reliability of these domains supports the emerging empirical consensus that spiritual distress and negative religious coping are measurable, clinically relevant constructs associated with delayed help-seeking, increased fear, and poorer outcomes.

By operationalizing spiritual-diabolical attribution as an interpretive risk factor, rather than a belief to be affirmed or dismissed, the PSSMHIS addresses a critical gap in both psychiatric and pastoral assessment. This approach enables clinicians and spiritual caregivers to engage spiritual narratives ethically while maintaining clinical responsibility.

The findings position the PS-SMHIS as a bridge instrument, facilitating collaboration between mental health professionals and spiritual caregivers. Its emphasis on discernment over validation aligns with ethical principles

in psychology, psychiatry, and pastoral care, particularly in contexts where spiritual explanations dominate illness narratives.

Limitations

Despite its promising findings, this study has several limitations characteristic of early-stage instrument development.

First, the sample size and sampling context limit generalizability. While appropriate for preliminary validation, larger and more diverse samples are necessary to ensure stability of reliability estimates across clinical, cultural, and religious populations.

Second, the present study focused primarily on **internal consistency reliability**. Future research should examine:

- Test–retest reliability to assess temporal stability
- Exploratory and confirmatory factor analyses to evaluate underlying factor structure
- Measurement invariance across gender, culture, and faith traditions

Third, criterion-related validity was not assessed. Future studies should compare PS-SMHIS scores with established psychiatric instruments (e.g., PANSS, YMRS, PHQ-9) to examine convergent and discriminant validity.

Fourth, the reliance on self-report data introduces potential response biases, particularly in religious contexts where stigma or theological framing may influence disclosure. Mixed-method approaches incorporating clinician ratings and qualitative interviews would strengthen construct validity.

Finally, while the scale assesses spiritual attribution without endorsing belief truth claims, cross-cultural validation is essential to ensure that item wording functions equivalently across diverse spiritual worldviews.

Future Research Priorities

Future studies should prioritize:

- Large-scale, multi-site validation
- Longitudinal designs examining whether PS-SMHIS use reduces the duration of untreated psychosis
- Clinical utility studies in integrated mental health–spiritual care settings
- Development of normative reference ranges

CONCLUSION

Informed by recent empirical research, the Psycho-Spiritual Severe Mental Health Indication Scale (PS-SMHIS) represents a timely and evidence-aligned response to longstanding challenges at the intersection of spirituality and severe mental illness. The scale demonstrates good to excellent internal consistency across clinical and psycho-spiritual domains, supporting its preliminary psychometric robustness.

By distinguishing psychiatric symptoms from spiritual distress and attributional risk, the PS-SMHIS aligns with contemporary empirical calls for integrative, culturally sensitive, and ethically responsible mental health assessment. With further validation, the scale holds promise for reducing harmful misattributions, improving help-seeking pathways, and fostering collaboration between mental health professionals and spiritual caregivers in diverse clinical contexts.

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APPENDIX

Instructions To Respondents

Below are statements describing experiences people may have had **during the past 12 months**. Please indicate how often each statement applies to you.

Response Options:

1 – Never

2 – Rarely

3 – Sometimes

4 – Often

5 – Almost Always

There are **no right or wrong answers**.

SECTION A

		1	2	3	4	5
1	I hear voices or sounds that others say are not present.					
2	I feel that others can influence or control my thoughts.					
3	I believe my thoughts can be accessed by others without my consent.					

4	I see things others cannot see.					
5	I strongly suspect others are plotting against me without clear evidence.					
6	My thoughts feel confused or disconnected.					
7	Others say my speech is difficult to follow.					

SECTION B

		1	**2**	**3**	**4**	**5**
8	I feel emotionally empty or detached most of the time.					
9	I struggle to feel joy or pleasure in daily life.					
10	I find it difficult to initiate activities or responsibilities.					
11	I withdraw from social or family interactions.					
12	I struggle to express emotions through words or facial expressions.					

SECTION C

		1	**2**	**3**	**4**	**5**
13	I experience periods of extremely elevated or irritable mood lasting at least one week.					
14	During these periods, I need much less sleep and still feel energized.					
15	I feel unusually powerful, important, or specially chosen.					
16	My thoughts race rapidly during these periods.					
17	I talk much more or faster than usual.					
18	I engage in risky behaviors without considering consequences.					
19	These periods cause serious problems in my life (conflict, hospitalization, job loss).					

SECTION D

		1	**2**	**3**	**4**	**5**
20	I experience noticeable increases in energy lasting several days.					
21	During these periods, I feel more productive or creative than usual.					
22	Others notice a clear change in my mood or activity level.					
23	These periods do not cause severe disruption to my functioning.					

SECTION E

		1	**2**	**3**	**4**	**5**
24	I feel persistently sad or hopeless for two weeks or longer.					

25	I lose interest in activities I previously enjoyed.					
26	I experience chronic fatigue or lack of energy.					
27	I feel worthless or excessively guilty.					
28	I have thoughts about death or not wanting to live.					

SECTION F

		1	**2**	**3**	**4**	**5**
29	I feel disconnected from meaning or purpose in life.					
30	My spiritual or religious beliefs feel confusing or distressing.					
31	I feel abandoned by God, fate, or a higher power.					
32	My mental distress interferes with my spiritual practices.					

SECTION G

Note: Respond based on your personal experience and interpretation.

		1	**2**	**3**	**4**	**5**
33	I believe my mental or emotional suffering is caused by evil spirits or demonic forces.					
34	I feel spiritually attacked, oppressed, or tormented by unseen forces.					
35	I experience intense fear related to demons, witchcraft, curses, or spiritual attacks.					
36	I interpret unusual thoughts or behaviors as signs of demonic influence.					
37	I feel a loss of control during these spiritual experiences.					
38	My fear of spiritual or diabolical forces interferes with my daily functioning.					
39	I avoid seeking psychological or medical help because I believe my problem is purely spiritual.					
40	Religious rituals, prayers, or deliverance practices have not reduced my distress.					
41	My spiritual interpretations increase my fear rather than bring peace or clarity.					

SCORING PROCEDURE

Subscale Scores

Index	Items	Domain
SSI	1–12	Schizophrenia Spectrum
MI	13–19	Bipolar I (Mania)
HMI	20–23	Bipolar II (Hypomania)

DI	24–28	Depression
SDI	29–32	Spiritual Distress
SDAI	33–41	Spiritual–Diabolic Attribution Index

INTERPRETATION GUIDELINES

Note that this is indicative only NOT diagnostic.

Schizophrenia Spectrum Indication

- Mean score ≥ **3.5** on SSI

- → Strong indication for schizophrenia spectrum disorder
  → Recommend psychiatric evaluation

Bipolar I Indication

- MI mean score ≥ **3.5**, especially Item 19
- Validation of the→ Strong indication for Bipolar I Disorder

Bipolar II Indication

- HMI mean score ≥ **3.0**
- AND DI mean score ≥ **3.5**

- → Indication for Bipolar II Disorder

High Spiritual Risk

SDI mean score ≥ **3.5**

→ Requires psycho-spiritual intervention alongside clinical care

Low SDAI (Mean < 2.5)

- Spiritual beliefs are not driving distress
- No spiritual attribution risk

Moderate SDAI (Mean 2.5–3.4)

- Spiritual explanations present
- Requires psycho-spiritual clarification and education

High SDAI (Mean ≥ 3.5)

- Strong spiritual/diabolic attribution of symptoms
- High risk of misattribution, fear escalation, and delayed treatment
- Requires integrated psychiatric + psycho-spiritual intervention

Critical Alert

- Item 28 score ≥ 4

- → Immediate clinical and pastoral safety response required

CRITICAL DISCERNMENT FLAGS

Psychosis–Spiritual Overlap Risk

- High **SSI** + High **SDAI**
- → Likely psychotic symptoms with spiritual content
- → Psychiatric evaluation is mandatory

Spiritual Bypass Risk

- High **SDAI** + refusal of medical care (Item 39 ≥ 4)
- → Risk of spiritualizing mental illness
- → Requires pastoral correction and referral

Pastoral Emergency

- High fear, loss of control, functional impairment
- → Do NOT pursue deliverance alone
- → Stabilize psychologically first

Clinical–Pastoral Guidelines

1. Always rule out medical and psychiatric causes first
2. Avoid affirming literal demonic explanations in acute psychosis
3. Emphasize:

- Safety
- Grounding
- Reality orientation
- Compassionate theological reframing

Not every spiritual interpretation indicates a spiritual cause; sometimes the mind uses spiritual language to express psychological distress. (Egunjobi, 2024)

Ethical Disclaimer

The PS-SMHIS is a screening and indication tool, not a diagnostic instrument.

Diagnosis must be made by a licensed psychiatrist or clinical psychologist using DSM-5-TR or ICD-11 criteria.

This assessment includes subjective spiritual experiences and interpretations. It does not confirm the existence of demonic causation. Claims of possession or extraordinary spiritual phenomena require medical, psychological, and ecclesial discernment and must never replace professional mental health care.

The spiritual-diabolical dimension may be theoretically aligned with:

- Catechism of the Catholic Church §§391–395, 1673
- Rituale Romanum (discernment before exorcism)
- Principle: “Extraordinary claims require extraordinary discernment.”