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ORIGINAL PAPER

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Religious delusions in patients admitted to hospital with schizophrenia

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Abstract *Background* Religious delusions are clinically important because they may be associated with selfharm and poorer outcomes from treatment. They have not been extensively researched. This study sought to investigate the prevalence of religious delusions in a sample of patients admitted to hospital with schizophrenia, to describe these delusions and to compare the characteristics of the patients with religious delusions with schizophrenia patients with all other types of delusion. *Method* A cross-sectional investigation was carried out. The prevalence of religious delusions was assessed and comparisons were made between religiously deluded patients and a control group on demographic, symptom, functioning and religious variables. One hundred and ninety-three subjects were examined of whom 24% had religious delusions. *Results* Patients with religious delusions had higher symptom scores (as measured by the PANSS), they were functioning less well (as measured by the GAF) and they were prescribed more medication than those patients with schizophrenia who had other types of delusion. *Conclusion* It is concluded that religious delusions are commonly found in schizophrenia and that by comparison with other patients who have schizophrenia, those patients with religious delusions appear to be more severely ill. This warrants further investigation.

Key words Schizophrenia – religious delusions – religion

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SPPE 524

Introduction

This study arose from a desire to establish the prevalence of religious delusions in a population of patients admitted to hospital with schizophrenia and to make a start in developing a cognitive model for the development of these delusions. Religious delusions are of interest because they may have an impact upon an individual's health belief model (Kelly et al. 1987) and, thus, their adherence to treatment. There have been a number of well-publicised cases, in which patients with what would appear to be religious delusions have acted upon these delusions with fatal consequences. Aside from the rare occurrence of these homicides, religious delusions are of clinical significance for two reasons. In case studies, religiously deluded people took literally statements in the bible to pluck out offending eyes or cut off offending body parts (Blackner and Wong 1963; Field and Waldfogel 1995; Kushner 1967; Waugh 1986). Religious delusions have also been associated with poorer outcomes from treatment (McCabe et al. 1972; Thara and Eaton 1996; Doering et al. 1998). The reasons for these consequences of religious delusions are unclear and the publications referenced do not always clearly specify a proposed mechanism of action for these consequences of having religious delusions. There have been few dedicated scientific investigations of religious delusions in schizophrenia.

The content of delusions has been shown to vary between populations and over time (Ndetei and Vadher 1984; Ndetei and Vadher 1985; Kent and Wahass 1996;

Al-Issa 1995). Religious delusions were more prevalent in the past than currently, though, even in a largely secular society, we still encounter people with schizophrenia who have a religious content to their delusions. To some extent this should be anticipated, since the majority of people, even in the UK, are reared within a culture where religious belief to some degree is the norm. Delusional ideas being on a continuum with normal beliefs (Harrow et al. 1988) is supported by a number of sources, with researchers concluding that normal religious beliefs are held in many cases as overvalued ideas, somewhere between delusions and "normal beliefs" (Jackson 1991; Strauss 1991; Jones and Watson 1997; Peters et al. 1999). It seems likely that many religiously deluded patients will have shifted along the continuum from the "normal" but overvalued religious ideas eventually to religious delusions.

When psychotic experiences are encountered, people seek causal explanations for these (Maher 1988) and will inevitably draw upon their existing knowledge and belief systems. In a recent model of positive symptoms of psychosis (Garety et al. 2001), biased appraisal is said to contribute to a tendency for anomalous experiences to "feel external", resulting in a cognitive style characterised by jumping to conclusions, external attributional bias and deficits in understanding social situations (Garety and Freeman 1999). Attribution theory offers a potential mechanism for the movement along this continuum towards religious delusions. Belief in the authenticity of auditory hallucinations as the voice of an omnipotent being such as God, speaking to them personally, could account for at least some patients with religious delusions. Religious people, not necessarily those with psychosis, have been shown to make religious attributions for events. Religious people are said to demonstrate an attributional style which is typically different from non-religious people (Shrauger and Silverman 1971; Proudfoot and Shaver 1975; Hood and Morris 1981; Spilka et al. 1985; Pargament and Hahn 1986; Jackson and Coursey 1988; Hood et al. 1990; Lupfer et al. 1992; Pfeifer 1994). Having a religious belief or having religious delusional belief provides a framework by which people can make sense of negative life experiences. This is said to be helpful to people as it allows them something of a buffer against the depressing effects of uncontrollable life stresses (Park et al. 1990).

To summarise, religious beliefs are fairly common and are not pathological. Religious people demonstrate an external attributional bias. A proportion of people will experience psychotic experiences, some of which will involve auditory hallucinations. There will be an attempt to make sense of these experiences and the religious people in particular are more likely to make sense of their psychotic experiences by developing religious delusions. These religious experiences and delusions may help the person to deal with the negative life events which they are faced with.

Since religious delusional explanations should be anticipated in any culture where religion is present, one might also expect that cultures in which religion is a more powerful influence would produce higher rates of religious delusions. This is in fact what has been established, with figures regarding the prevalence of religious delusions in schizophrenia varying from 7 % in Japanese patients, 21 % in Germans (Tateyama et al. 1993) up to 80 % (Kiev 1963) in Afro-Caribbean populations. It is clear that the prevalence of religious delusions varies massively between populations, though there are differences in definition of religious delusion which may affect the prevalence rates. In many of the studies mentioned, the actual definition of what was considered a religious delusion was not outlined.

A clear definition of religious delusions can be established from a set of criteria published by Sims (1995). These criteria could be utilised to ensure reliability and also ensure that normal socially acceptable religious beliefs were not mis-classified as being religious delusions. According to these criteria, a belief can be characterised as a religious delusion if it meets the following characteristics:

1. both the observed behaviour and the subjective experience conformed with psychiatric symptoms in that the patient's self-description of the experience was recognisable as having the form of a delusion;
2. there were other recognisable symptoms of mental illness in other areas of the individual's life; other delusions, hallucinations, mood or thought disorder and so on;
3. the lifestyle, behaviour and direction of the personal goals of the individual after the event or after the religious experience were consistent with the natural history of mental disorder rather than with a personally enriching life experience.

Delusions are recognised to be multidimensional phenomena, continuous with normality (Garety and Hemsley 1994). Since there has not yet been an extensive investigation of the phenomenon of religious delusions, we are unable to say if or how each of the dimensions of religious delusions might differ from the dimensions of other delusions. In particular, we are unable to evaluate whether any differences might offer a mechanism for the findings indicated earlier, relating to poor outcomes in patients with religious delusions. One dimension which could affect both response to command hallucinations and attributions is belief conviction. It has been shown (Applebaum et al. 1999) that religious delusions are held with greater conviction than other types of delusion. Reaction to hypothetical contradiction (Brett-Jones et al. 1987) is another measure of the severity of a delusion. It can be used to evaluate the patient's responsiveness to evidence, contrary to the delusional idea. This measure can be used as a predictor of change, whilst also giving an additional indication of the certainty of the delusion and the patient's tendency to incorporate contradictory evidence into a delusion. Low scores on this measure are indicative of a dismissal of relevant evidence, a factor likely to contribute to delusion maintenance. As well as conviction and reaction to hypothetical contradiction,