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REVIEW

Religious delusions: Definition, diagnosis and clinical implications

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----------ABSTRACT----------

The prevalence of the biopsychosocial model in psychiatry highlights the importance of investigating the clinical significance of religiosity in patients with psychotic disorders. Due to the spiritual and supernatural nature of religious beliefs, distinguishing them from religious delusions is a challenging endeavour. The self-referential nature of the beliefs, the presence of concomitant psychiatric symptomatology and the effect on functionality seem to play a key role in differential diagnosis. Religious psychotic symptoms are common in clinical practice. The study of these symptoms often becomes difficult due to varying definitions, the fluctuation they present over time and space and the strong influences of the social and cultural environment on them. There seems to be a positive correlation between religiosity and the occurrence of religious delusions in psychotic patients, but it is not clear that this indicates a causal relationship. The content of religious delusions seems to be significantly influenced by the immediate social environment rather than cultural background of the individual, as well as by the beliefs and attitudes of the patient's family environment. Religious delusions are characterized by increased conviction and pervasiveness, permeating to a greater extent the individual's whole experience. Their presence is associated with more severe symptoms, higher medication dosage, and poorer prognosis. The increased severity of psychosis with religious content symptomatology seems to be associated with genetic factors and greater genetic load. In addition, the increased duration of untreated psychosis is a determinant of prognosis. This may reflect a reduced alertness of the immediate environment of patients who develop psychotic symptoms with religious content for the first time. Other important prognostic factors are patients' lack of adherence to treatment, their greater resistance to psychiatric approach of the disorder and their exclusion from religious communities, as well as the special characteristics of religious delusions, which seem more corrosive to the patients' psyche than other delusions. Religion and spirituality are prominent in the lives of the majority of patients with psychosis, but they are often underestimated in clinical practice. Raising the awareness of mental health professionals on issues of a religious and spiritual nature can be beneficial in both preventing and treating psychotic disorders.

KEYWORDS: delusions, religious delusions, religiosity, psychotic disorders

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Introduction

Despite the progressive "disenchantment" of the world and the secularization of societies, the need for transcendental and religious experiences still seems to be a constant feature of the personal and social lives of the majority of people. The role that religion and religiosity play, in the development and the prognosis of psychopathological conditions remains unclear and should be thoroughly investigated. A major area of this line of research is psychotic symptoms with religious content, which are so frequently found in clinical practice.

Differences between religious beliefs and religious delusions

Distinguishing religious delusions from non-delusional religious beliefs seems to be a difficult and multidimensional task, which has aroused the interest of many scholars internationally. As the content of religious beliefs is supernatural and goes beyond the scientific terms of understanding the world, religious beliefs can be misinterpreted as delusional. The DSM's definition of delusional ideas and, consequently, the definition of religious delusional ideas seem to be confusing due to some disadvantages and ambiguities which we will try to list.

Patients with religious delusions seem to maintain their beliefs in a qualitatively different way from healthy religious individuals.[1] The religious person may be possessed by doubts about his/her beliefs or at least recognize that the existence of doubts in others is rational.[2] In addition, he/she may need even a hint of strengthening his/her faith, while the person with religious delusions has an unshakable and self-proven "faith". Geiderman suggests that religious belief exists only when there is doubt.[3] For the religious individual, faith is ultimately a matter of choice, while in the person with delusions "the absolute truth" is revealed to him/her, to which he/she surrenders completely. Spitzer emphasizes that delusions represent "claims of knowledge" and not "claims of faith".[4]

Delusions are not combined with intuition. Patients with psychosis are usually unaware of the impossibility and paradox of their claims and may even "embellish" them, while the non-psychotic individuals usually acknowledge the peculiar nature of their own claims of faith.[1, 5] The way of thinking of the religious people is abstract and spiritual. On the contrary, delusional thoughts, experiences, actions are specific and literal. Typically, when patients with delusions say that they feel God inside them, they say it in a literal way and they can determine exactly where they feel him (for example in a specific organ or part of their body). That is, they describe it as a physical and sensory experience.[6]

In addition, religion (especially the modern "secularized" doctrines) is overwhelmed by symbolic speech, while the understanding of the world in psychosis is possessed by extreme literacy. This thought disorder, the so-called concrete or rigid thinking, characterizes the delusional structure of psychosis.[6] Extreme examples of this delusional aspect are the cases of patients, who performed self- or hetero-amputation operations (castration, amputation of limbs, eye extraction) receiving with extreme literacy the scriptures.[7-9] Ames in 1987 proposed the naming of such practices of self-castration, in the context of religious delusions, as Klingsor Syndrome[8] , from the homonymous character of Wagner's opera "Parsifal", who castrated himself as he was unable to control his libido. It is noteworthy that patients often report that they feel no pain but relief during the act of castration, and then express little or no remorse, as they do not recognize their behavior as irrational, but as a means of purification and salvation. Most of these patients refuse to undergo remedial surgery and if they reluctantly accept it, they strongly resist the subsequent treatment and rehabilitation process, while there are many cases of patients who re-amputated the rehabilitated body part themselves.[9] To distinguish between delusions and non-delusional religious beliefs, the DSM-5 adopts the criterion of acceptance of the religious beliefs by other community members (“members of the person's culture or subculture”), instead of a criterion about the control of beliefs’ validity.

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Consequently, religious beliefs could be considered non-delusional despite the blatant lack of scientific validation. On the other hand, this DSM-5 criterion seems to protect the believers of the established religious doctrines and consequently to easily pathologize other temperamental and unpopular beliefs.[10]

This also raises the question: what happens if a delusion is adopted by others. Based on the abovementioned criterion of "sharing", it should be considered by definition a non-delusional belief. Kauffman in 1939 notes that the person who believes he is the Messiah is considered psychotic until there is a group of people who will accept him as such and in this group this belief represents a religious system. Beyond the delusional system of the person claiming to be the Messiah, other parameters in his delusion enable him to have an impact on other people and help him cover some of his needs.[10]

However, delusion can also be shared, which is typically the case in shared psychotic disorder (follie a deux). It usually occurs between two individuals, less often in three and four individuals, but there have been also cases involving many more people (follie a famille or follie a douze).[11] The question is how many people have to share an idea in order to consider it "normal". Religious doctrines present a special challenge for answering this question. In the United States of America, new religious groups with distinctive and idiosyncratic beliefs, often emerge and they are called new religious movements (NRMs). On the other hand, small religious group can become an internationally accepted religion, as has already happened with Mormons or even in the case of Christianity.[10] Scholars who have studied the dynamics that develop in such groups, the so-called "charismatic groups" or heresies, have found a "charismatic" leader, who forms a belief system, develops a special atmosphere and applies a control mechanism in order to suppress opposing views. In this way, the other members of the group adopt a structure of beliefs, usually with secondary benefits and a sense of belonging somewhere as a mental reward, so they do not meet the criteria of having delusions. This holds true if we accept as characteristic of delusions that they form either in conditions of isolation of an individual, or despite the opposite view of others.[10] However, in the case of a leader with delusional beliefs, the acceptance of his/her delusions could fit the model of shared psychosis, in which the other members of the closed and entrenched group play the role of the submissive and dependent party.[11]

Criteria of functioning are the most practical and applicable for the evaluation of human behavior. Central role in attempting to distinguish "normal" religious beliefs from religious delusions has the criterion of the effect of beliefs on the functioning of the person who embraces them.[5] That is, if the social and professional life of the person who has the religious beliefs or the religious experience is not affected, then they are not considered pathological.
Perhaps the most noticeable difference between a healthy religious person and a person with religious delusions is that the healthy person may consider that he/she has a personal relationship with God, but this is in line with the teachings of his/her religion and in the way it is accepted to exist. In religiosity there is a religious connection with the "sacred" element, but it is generalizable. The believers do not consider that they have any special relationship with God, but that everyone is connected in some way with the divine. On the other hand, patients with delusions believe that they have a unique or privileged relationship with God, or even that they are the religious entities themselves. The self is the center of their religious delusions.[12]
Table 1 summarizes the differences between religious beliefs and religious delusions.

Religious delusions

Psychotic symptoms with religious content are most commonly presented as religious delusions and religious hallucinations. They are often encountered in clinical practice and their rate has been estimated at 1.1%-80% (20% -60%).[13] This large variation is due to some methodological difficulties faced in the study of psychotic symptoms with religious content,

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such as the difficulty of defining them, i.e., distinction between religious delusions religious beliefs, difference between religiosity and spirituality. Moreover, the prevalence of religious delusions varies in different cultures and different time periods.[1, 14] In Egypt, for example, fluctuations in the prevalence of religious delusions over a 20-year period have been linked to shifts in the emphasis on religious issues in Egyptian society, in times of socio-political tension and an escalation of religiously motivated violence.[15] In addition, a retrospective 40-year sampling study in patients with schizophrenia in Poland, found a gradual decrease in the prevalence of religious delusions. This can be related to a cultural shift from Catholicism to a more secular society. It is worth noting that religious issues seemed to go hand in hand with socio-political changes in the country, such as the rise of the Polish Pope to the papal throne or the rise of the Communist regime.[16]

Finally, social environment seems to play an important role. In cultural environments that are more tolerant of diversity religious delusions are underestimated, while more conservative environments that maximize the peculiarity of minority's beliefs. Moreover, religious delusions with content compatible with the religious beliefs of each environment are less frequently identified as pathological compared to religious delusions with content different from the dominant religious beliefs.

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Etiology

No causal relationship between increased religiosity and the prevalence of religious delusions in the general population has been found.[17] On the contrary, there appears to be a positive correlation between religiosity and religious delusions in those already suffering from a mental illness.[18] This finding may indicate that when a person develops a mental disorder, his delusions reflect his own prevailing interests and concerns.[6,19] The religiosity level seems not directly related to clinical severity, but it seems to be a better predictor of religious delusions than religious affiliation status.[20] Moreover, people who attribute their symptoms to religious explanations are more likely to form religious delusions.

Recent studies have linked the increased likelihood of religious delusions formation to both environmental and genetic factors. Patients who report high religious activity are more than three times more likely to experience religious delusions. Moreover, patients with schizophrenic disorders who exhibit a high genetic predisposition are more likely to develop psychotic symptoms with religious content.[21]

Content

Religious delusions may be presented in various ways and their contents differ. The following categories can be distinguished regarding the content of religious delusions:

(1) Delusions of persecution (by the devil, demonic entities etc.)

(2) Grandiose identity delusions (Messiah Syndrome, undertaking special mission)

(3) Delusions of guilt or devaluation (unforgivable sins)

(4) Delusions of control or passivity phenomena

(5) Delusional misidentification syndrome or antichrist delusion (the delusional misidentification of oneself or others as the Antichrist, which, although relatively rare, is of particular clinical significance, because it is often accompanied by violent, mostly hetero-destructive, behaviors).[22, 23]

Characteristics

The immediate social living environment has a greater influence than the cultural background on the content of delusions and hallucinations. In a study conducted in UK the content of delusions and hallucinations was compared in 3 groups of patients with schizophrenia, British White (BW), British Pakistani (BP) and Pakistan Pakistani (PP). The results showed a greater degree of similarity of the content between of BW and BP than between BP and PP.[23]

In addition, the influence of beliefs and attitudes of the patients' family environment play an important role on the manifestation of religious delusions. In a survey in Southwestern Greece, the majority of healthy mothers (85%) of patients with delusions with religious or magical content attributed their children's mental illness to demon possession or magical influence. This finding was found mainly in families with low educational level, while it was quite common to resort to "therapeutic" practices, except psychiatric treatment, such as exorcism.[24, 25]

According to a study which was conducted in three cities (Vienna, Tübingen, Tokyo), delusions with religious content are more common in European patients (20-21%) than in Japanese patients (6.8%). In fact, while delusions of grandiosity are common in all three regions, delusions of guilt and sin appear only in 2 out of 22 (9.1%) Japanese but in 12 out of 32 (37.5%) Germans and in 9 out of 20 (45%) Austrian patients.[26]

In addition, delusions of guilt and sin seem to be more prevalent in societies with a Christian Jewish religious tradition, while they are uncommon in Islamic, Hindu, and Buddhist societies.[26-28] Catholic Christian patients (15.5%) present more religious delusions of guilt than Protestant or Muslim patients (3.8%).[29] Protestant patients report religious delusions more often than Catholic patients or non-Catholic patients or patients with no religion affiliation.[30] Members of the New Religious Movements show higher scores on the measurement scales of delusional ideation in relation to members of Christian or no-religious social groups.[31]

Delusions of persecution and religious delusions show the strongest impact on the lives of patients, while there is over-representation of religious delusions in schizophrenic patients compared to bipolar or depressed patients. In fact, religious delusions show higher scores in the dimensions of conviction and pervasiveness (pervasiveness reflects the degree to which delusions permeates the entire experience of the individual).[32]

Finally, the delusional characteristics bizarreness, frequency of psychotic symptoms, and degree of distress were more prevalent for religious delusions than for any other type of delusion.[33]

Prognosis

As early as in 1996, Thara & Eaton reported that specific symptoms at the time of hospital admission, namely delusions of grandiose or regarding sexuality, bizarre thoughts and blunted affect, are strongly related to poor prognosis of patients with psychosis and religious delusions.[34]

In a study conducted in UK a sample of 193 patients with religious delusions in Manchester hospitals where compared to a group of schizophrenia patients with delusions of different content and found that the first group had higher scores in Positive and Negative Syndrome Scale (PANSS), poorer functionality, measured using the Global Assessment of Functioning

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(GAF) and higher doses of medication.[18] On the other hand, it has been proposed that possible biases in psychiatrists, who are considered to be less religious, belong to a group with lower rates of religious belief, may result in more aggressive treatments towards patients with religious delusions.[10] In the aforementioned UK study, the response of the above patients to the treatment was re-evaluated two years later. It was found that the symptoms of patients with religious delusions were more severe both before and after treatment, but the response to treatment was similar in both groups.[34]

The increased severity of psychosis with religious content symptomatology seems to be related to genetic factors. Individuals with a higher genetic burden are more likely to experience religious delusions.[21]

The duration of untreated psychosis (DUP) is a particularly crucial factor. It is reported that upon admission patients with religious delusions show a more extensive course of disease, i.e. they have been exposed for a longer period of time to psychotic symptoms.[35] Patients with religious delusions cause less anxiety in their family than patients with delusions of other content. This is a possible explanation for the fact that patients with religious delusions present with a more severe symptoms at the time of admission than other patients with delusions.[18, 35]

Another dimension of great prognostic value is patient's compliance with treatment. Religious delusions can have a negative effect on a patient's consistency in treatment when he attributes his psychotic symptoms to supernatural entities.[36] Moreover, cases are often reported of patients refusing to continue medication because it prevents them from praying or because they prefer to hear the voice of God or find answers in the Bible.[36-38]

Previous studies found that patients with religious delusions did not have a worse clinical status than patients with other delusions and concluded that the worst prognosis of the former is due to the greater resistance they show to psychiatric treatment and the less support they receive from religious communities.[20,36] These patients seem to be at a disadvantage as they are far from both science (poorer therapeutic alliance-"competition" between religion and psychiatry) and the religious community (rejection due to dysfunctional behaviors induced by their delusions).[36]

Other studies in schizophrenia patients with religious delusions have shown increased disease severity and the poorer effects of treatment in these patients, which were mainly attributed to: (a) delayed access to mental health services (in religious settings religious delusions skip the attention of their relatives or initially, religious rituals are preferred as "therapy"), (b) to the reduced cooperation in psychiatric treatment (due, for example, to the patients' preference to hear the voice of God), and (c) to the special characteristics of the religious delusional ideas, which seemed more corrosive to the patients' psyche and were maintained with greater vigor.[30, 39-43]

Discussion

We can think of religious beliefs as a continuum ranging from normal religious beliefs to religious delusions. Where a belief lies in this continuous depends on the intensity of the various dimensions of delusionality. Among them, the self-referential nature of the belief, the

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presence of other psychiatric symptoms and the effect on functionality seem to play a key role in differential diagnosis.

The difficulty of distinguishing religious delusions from religious beliefs is more prominent in multicultural societies (where a person's peculiar beliefs, which seem strange and can be misinterpreted as delusional, may correspond to a peculiar cult). In societies with a dominant religion, like Greece, the problem is not so obvious, but taking into account the constant movement of populations and the increase of the immigrant and refugee communities, it is something that can be a particular challenge in the future.

While religion and religiosity are prominent in the lives of many psychotic patients, in clinical practice issues of a religious and spiritual nature may be overlooked and sometimes devalued by clinicians. Indicatively, it is reported that while 90% of Americans say they believe in the existence of God, only 40-70% of psychiatrists and 43% of psychologists share this belief, and this may be reflected in a bias towards identifying pathological aspects of religiosity.[10] This divergence is certainly not just a phenomenon of the modern age. As early as the turn of the last century, the founder of psychoanalysis, Sigmund Freud, adopted a strong anti-religious stance that had a great influence on the scientific community.[44] Although there has been a historical rivalry between the fields of psychiatry and religion and prejudices and dogmas have prevailed on both sides, due to their different and largely opposite ontological approach and interpretation of the world, we must not forget that the common denominator is human mental pain and its relief.

It could therefore be considered more than reasonable, if not necessary, for mental health professionals to be aware of issues of a religious nature because of the importance that patients attach to them. Several authors, moreover, suggest the establishment of an alliance between mental health clinicians and religious ministers[20]. Psychiatrists could be more sensitive to religious and spiritual aspects of patients' personalities and their potential positive effects on mental health, while religious practitioners could better identify the boundaries between healthy religiosity and the pathological experiences or denial of mental illness and treatment due to religious beliefs. The benefits of such a therapeutic partnership can be of great importance both for the prevention and for the more effective treatment of mental disorders.

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Table 1. Characteristics of religious delusions versus non-delusional religious beliefs.

Non-delusional religious beliefs	Religious Delusions
Quality of faith	
• doubts about beliefs	• unshakable faith
• may need a hint of faith	• self-proven faith
• faith is ultimately a matter of choice	• revelation of "the absolute truth", followed by complete surrender
• "claims of faith"	• "claims of knowledge"
• acknowledgement of the peculiar nature of the claims of faith	• unaware of the impossibility and paradox of the claims of faith
Speech – thought	
• abstract and spiritual way of thinking	• concrete or rigid thoughts
• symbolic speech and scripts	• specific experiences and literal actions
Share – acceptance of beliefs	
• religious beliefs accepted by other community members	• delusional beliefs are unpopular and not accepted by others inside the community
Functioning	
• social and professional life not affected	• impaired social and professional life
Relationship with God	
• no special relationship with God, religious connection is generalizable	• unique or privileged relationship with God
• everyone is connected in some way with the divine	• the self is in the center of the religious delusions

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ΑΝΑΣΚΟΠΗΣΗ

Θρησκευτικές παραληρητικές ιδέες: Ορισμός, διάγνωση και κλινική σημασία

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----------**ΠΕΡΙΛΗΨΗ**----------

Η επικράτηση του βιοψυχοκοινωνικού μοντέλου στην επιστήμη της ψυχιατρικής αναδεικνύει την σπουδαιότητα της διερεύνησης της κλινικής σημασίας της θρησκευτικότητας σε ασθενείς με ψυχωτικές διαταραχές. Λόγω του πνευματικού και υπερφυσικού χαρακτήρα των θρησκευτικών πεποιθήσεων, η διάκριση αυτών από τις θρησκευτικές παραληρητικές ιδέες αποτελεί απαιτητικό εγχείρημα. Καίριο διαφοροδιαγνωστικό ρόλο φαίνεται να διαδραματίζουν η αυτοαναφορική φύση της δοξασίας, η παρουσία συνοδού ψυχιατρικής συμπτωματολογίας και η επίδραση στη λειτουργικότητα. Τα ψυχωτικά συμπτώματα με θρησκευτικό περιεχόμενο απαντώνται συχνά στην ψυχιατρική κλινική πράξη. Η μελέτη των ανωτέρω συμπτωμάτων καθίσταται δυσχερής, λόγω αντικειμενικών δυσκολιών που αφορούν τις διαφοροποιήσεις στον ορισμό αυτών, την διακύμανση που παρουσιάζουν στην πορεία του χρόνου και την ισχυρή επιρροή που ασκείται από το εκάστοτε κοινωνικό και πολιτισμικό περιβάλλον σε αυτά. Φαίνεται να υπάρχει θετική συσχέτιση μεταξύ θρησκευτικότητας και εμφάνισης θρησκευτικών παραληρητικών ιδεών στους πάσχοντες ψυχωτικούς, χωρίς όμως να είναι ξεκάθαρο αν η σχέση είναι αιτιοπαθογενετική. Το περιεχόμενο των θρησκευτικών παραληρητικών ιδεών φαίνεται να επηρεάζεται σημαντικά από το άμεσο κοινωνικό περιβάλλον διαβίωσης του ατόμου καθώς και από τις πεποιθήσεις και στάσεις του οικογενειακού περιβάλλοντος του ασθενή. Οι θρησκευτικές παραληρητικές πεποιθήσεις χαρακτηρίζονται από αυξημένες τιμές βεβαιότητας διαποτίζοντας σε μεγαλύτερο βαθμό το σύνολο των εμπειριών του ατόμου. Η παρουσία τους σε ασθενείς με ψύχωση συνδέεται με βαρύτερη συμπτωματολογία, υψηλότερη δοσολογία φαρμακευτικής αγωγής και πτωχότερη πρόγνωση. Η αυξημένη βαρύτητα της ψύχωσης με θρησκευτικού περιεχομένου συμπτωματολογία φαίνεται να συνδέεται με γενετικούς παράγοντες και μεγαλύτερο γενετικό φορτίο. Επιπλέον, καθοριστικό προγνωστικό παράγοντα αποτελεί και η αυξημένη διάρκεια της μη θεραπευμένης ψύχωσης (DUP). Αυτό μπορεί να αντανακλά μειωμένη εγρήγορση του εγγύτερου περιβάλλοντος των ασθενών που πρωτοεμφανίζουν ψυχωτική συμπτωματολογία με θρησκευτικό περιεχόμενο. Άλλες σημαντικές διαστάσεις προγνωστικού χαρακτήρα αποτελούν η ελλιπής συμμόρφωση των ασθενών στη θεραπεία, η μεγαλύτερη αντίσταση που προβάλλουν απέναντι στην ψυχιατρική αντιμετώπιση της διαταραχής και τον αποκλεισμό τους από τις θρησκευτικές κοινότητες, καθώς και τα ιδιαίτερα χαρακτηριστικά των θρησκευτικών παραληρητικών ιδεών, οι οποίες φαίνονται περισσότερο διαβρωτικές για τον ψυχισμό σε σύγκριση με άλλες παραληρητικές ιδέες. Η

θρησκεία και η πνευματικότητα κατέχουν προεξάρχουσα θέση στη ζωή της πλειονότητας των ασθενών με ψύχωση, ωστόσο στην κλινική πράξη συχνά υποτιμώνται. Η ευαισθητοποίηση των επαγγελματιών ψυχικής υγείας πάνω σε ζητήματα θρησκευτικής και πνευματικής φύσεως μπορεί να αποδειχθεί ωφέλιμη τόσο για την πρόληψη όσο και για τη βέλτιστη αντιμετώπιση των ψυχωτικών διαταραχών.

ΛΕΞΕΙΣ ΕΥΡΕΤΗΡΙΟΥ: παραληρητικές ιδέες, παραληρητικές ιδέες θρησκευτικού περιεχομένου, θρησκευτικότητα, ψυχωτικές διαταραχές.

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