

How to care for patients who have delusions with religious content

To improve outcomes, look beyond delusion content and enlist spiritual care experts

Mr. D, a 72-year-old Christian with a long history of schizophrenia, presents to the emergency room with concerns about evil spirits in his home who have poisoned him. He has called for police assistance on numerous occasions and has tried to kill the evil spirits with his rifle, but states “they are bulletproof.” He is unable to sleep and is “fearful for my life every night because that is when the demons come out.” Mr. D also believes that God is “more powerful than the evil spirits.” Two elders at his church have prayed with him and encouraged him to go to the hospital.

Delusions with religious content (DRC) are associated with poorer clinical outcomes and dangerousness.¹⁻⁶ Most mental health professionals will encounter patients with DRC because this type of delusion is relatively common in patients with symptoms of mania or psychosis. For example, in a study of 193 inpatients with schizophrenia, 24% had religious delusions.¹ The prevalence of DRC varies considerably among populations and can be influenced by the local religion and culture.⁷⁻⁹ This article reviews clinical challenges and assessment and management strategies for patients with DRC.

A challenging course

In a UK study of 193 inpatients with schizophrenia, compared with patients with other types of delusions, those with DRC:

- had higher Positive and Negative Syndrome Scale scores and lower Global Assessment of Functioning scores

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Sara M’Lis Clark, MD

Psychiatry Resident, PGY-III

David A. Harrison, MD, PhD

Assistant Professor

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Department of Psychiatry and Behavioral Sciences
University of Washington
Seattle, WA



Delusions with religious content

Clinical Point

Working with spiritual care professionals may help reduce clinician biases that could pathologize a patient's religiosity

Table 1

Assessing patients with DRC

Use caution when making a diagnosis to decrease risk of pathologizing religious beliefs

Do not focus solely on the content of the delusion; instead look at conviction, pervasiveness, bizarreness, and associated distress

Look at the spiritual/religious context and deviations from conventional religious beliefs of the patient's culture

Establish an open dialogue with the patient, the family, and individuals from the patient's faith community to understand the psychosocial issues and any reservations about psychiatric care

Be aware of the categories of delusions, especially those associated with harm (eg, grandiose antichrist delusions, guilt delusions, and some persecutory delusions)

Perform a thorough safety assessment that includes previous self-harm, drug use, and severity of mental illness

Be vigilant for patients who are actively seeking evidence to support their misguided/dangerous beliefs

DRC: delusions with religious content

Source: References 2,12,16-18

- waited longer before reengaging in treatment
- were prescribed more medications.¹

In addition, compared with patients with other types of delusions, patients with DRC often hold these delusions with greater conviction,^{1,2} making them more challenging to treat.

Dangerousness in patients with DRC can manifest as self-harm or harm to others. Extreme examples include self-inflicted enucleation of the eye and auto-castration. In a review of 9 cases of severe ocular self-injury, 4 patients had DRC.³ Genital self-mutilation associated with DRC is rare, but several cases of psychotic men who performed auto-castration based on a literal, erroneous interpretation of a passage in the Bible (Matthew 19:12) have been reported.^{4,5} Patients with DRC have committed rape and murder because they believed they were the antichrist.⁶

In this article we use the phrase "delusions with religious content" instead of "religious delusions" because this dis-

inction highlights that many subtypes of delusions can have a religious theme. Categories of delusions with religious themes include:

- persecutory (often involving Satan)
- grandiose (messianic delusions)
- guilt delusions.

Categorizing DRC is important because some are associated with more distress or dangerousness than others. For example, case studies of self-inflicted eye injuries found that most patients had guilt delusions with religious themes that referenced punishing transgressions, controlling unacceptable sexual impulses, and attaining prescience by destroying vision.^{3,10} In our example, Mr. D is experiencing a persecutory DRC. Also, using the label "religious delusion" can inadvertently pathologize religious experiences.

Tips for effective evaluation

DSM-IV-TR offers no specific guidelines for assessing DRC vs nondelusional religious beliefs.¹¹ There is risk of pathologizing religious beliefs when listening to content alone.¹¹⁻¹⁵ Instead, focus on the conviction, pervasiveness,² uniqueness or bizarreness, and associated emotional distress of the delusion to the patient (*Table 1*).^{2,12,16-18}

In the context of the patient's spiritual history, deviations from conventional religious beliefs and practices are important factors in determining whether a religious belief is authentic or delusional. Involving family members and/or spiritual care professionals (eg, chaplains and clergy) can be especially helpful when making this differentiation.^{16,17} In the hospital, chaplains often are familiar with a variety of faith traditions and may provide important insight into the patient's beliefs. In the community, clergy members from the patient's faith also may provide valuable perspective.

Similar to how having a basic familiarity with a patient's culture can improve care, a better understanding of a patient's spiritual or religious beliefs and practices can build rapport and the therapeutic alliance.^{16,17} This is particularly important with patients with DRC because these in-

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dividuals often have a poor therapeutic alliance and engagement with providers.¹⁹ Because many psychiatrists have limited time and may not be familiar with every patient's spiritual or religious background, consultation with spiritual care professionals may be helpful.

Assess whether your patient has reservations about psychiatric treatment. Some may believe that seeking care from a doctor is evidence of weak faith, whereas others may feel that psychiatric treatment is forbidden or incompatible with their religious beliefs.¹⁹⁻²² Mental health clinicians need to consider their own religious biases that may cause them to minimize or pathologize a patient's religiosity.^{20,23} Working collaboratively with spiritual care professionals may help reduce clinician biases or assumptions.²⁴

Evaluating safety

When constructing a differential diagnosis and evaluating patients for safety, remember that DRC are a feature of many psychiatric disorders (eg, persecutory DRC in schizophrenia, grandiose DRC in mania). Consider the course and severity of the patient's illness, and determine if he or she has a history or evidence of self-injury or substance abuse. Be cognizant of the categories of delusions in the context of the diagnosis. For example, grandiose delusions that involve the antichrist can be associated with harm toward others.⁶ Patients who express extreme feelings of guilt or shame (as seen in psychotic depression) and the need to be physically punished may be at risk for self-harm. Finally, patients seeking evidence to support misguided and dangerous beliefs—for example, obsessing over a religious text regarding self-injury while in a delusional state—may be at high risk for self-harm.¹⁸

Researchers have suggested clinicians question patients to determine if they trust their delusions.²⁵ Patients who trust their delusions may appear calm if they already have decided to act on their thoughts.²⁵ Preventive measures for patients at risk of self-harm include close observation, hospitalization, and pharmacotherapy.

Table 2

Treating patients with DRC

If a patient is at risk for self-harm or harming others, take preventive measures such as hospitalization or close observation

Rapid tranquilization may be necessary to reduce risk of harm

Encourage positive religious coping and spiritual practices, when appropriate

DRC: delusions with religious content

Source: References 5,18,25,26

Pharmacotherapy for DRC

There are no clear recommendations on specific psychotropics or dosages for treating patients with DRC. When a patient with DRC is at high risk of self-harm or harming others, using antipsychotics, anxiolytics, hypnotics, or a combination of these agents sometimes is needed to quell agitation, along with close observation and restraints when necessary (*Table 2*).^{5,18,25,26} Mr. D benefited from risperidone, 3 mg at bedtime, and zolpidem, 10 mg as needed for insomnia.

Using spirituality to cope

Many persistently mentally ill patients identify themselves as religious and use religious activities or beliefs to cope with their illness.^{27,28} In a study of 1,824 seriously mentally ill patients, self-reports of religiousness were positively associated with psychological well-being and diminished psychiatric symptoms.²⁹ Longitudinal research has shown that some aspects of spirituality and religion are associated with positive mental and physical health effects, whereas other aspects can worsen symptoms.³⁰ Specifically, positive religious coping such as benevolent religious reappraisals (eg, "Jesus is my shield and savior"), collaborative religious coping, and spiritual support are associated with positive mental health.³¹ However, negative religious coping, such as punishing God reappraisals and reappraisals of God's power (eg, "my illness is punishment for my sins"), are associated with distress and personal loss.³²

Clinical Point

Patients who are seeking evidence to support misguided and dangerous beliefs may be at high risk for self-harm



Delusions with religious content

Clinical Point

For some patients with psychosis, religious beliefs can be a source of meaning, hope, strength, and recovery

Table 3

When to elicit help from spiritual care professionals

To better understand the patient's religious background
To reduce biases when the clinician comes from a different religious background or no religious background
To help identify positive and negative religious coping, and to reinforce positive coping
To connect or reconnect patients to members of their faith community or to help them find a religious community

For patients with psychotic disorders—and with schizophrenia in particular—religious beliefs can be a source of meaning, hope, strength, and recovery. In a study of 115 outpatients with psychosis, 71% used positive religious coping, compared with 14% who used negative religious coping.³³ Among 38 patients with DRC, 45% used spirituality and religion to help cope with their illness, even though they received less support from religious communities than patients with other types of delusions.¹⁹ In this study, the authors suggest that positive religious coping among patients with DRC may alleviate delusion severity by decreasing levels of conviction and fear and preventing maladjusted behaviors.¹⁹ Religious beliefs and activities are associated with fewer hospitalizations among patients with persistent mental illness²⁸ and are a significant protective factor against suicide in patients with psychotic disorders.^{34,35} However, some studies have found that intense, obsessive participation in spiritual activities can worsen psychiatric symptoms and undermine recovery.^{1,36,37}

Addressing religion in treatment.

Although many studies have emphasized the importance of religion to patients with psychosis, evidence-based guidelines on how best to address religion/spirituality in the clinical setting in patients with psychosis have yet to be established. In a 2011 study, a spiritual assessment was well tolerated by 40 patients with psychotic disorders and improved patients' appointment

attendance compared with a control group who received traditional care only.²⁶

Many mental health providers feel ill-equipped or are uncomfortable exploring spiritual or religious issues with patients. Enlisting the help of spiritual care professionals when assessing patients with DRC may improve evaluation and care (Table 3). Spiritual care professionals typically are experienced in exploring subjects associated with DRC, such as guilt, morality, conscience, repentance, and confession.²⁴ Spiritual care professionals also may be able to assist patients with religious coping and provide comfort and support.

Finally, spiritual care professionals can help patients connect or reconnect to a spiritual or religious community. In Mr. D's case, the hospital chaplain deterred him from focusing on the reason the evil spirits were trying to punish him and guided him toward positive religious coping. Mr. D felt we were listening to him on a deeper level and understanding his spiritual struggles. The chaplain's involvement also enhanced Mr. D's relationship with the psychiatrist.

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Related Resources

- Mohr S, Borrás L, Betrisey C, et al. Delusions with religious content in patients with psychosis: how they interact with spiritual coping. *Psychiatry*. 2010;73(2):158-172.
- Huguelet P, Mohr S, Betrisey C, et al. A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. *Psychiatr Serv*. 2011;62(1):79-86.

Drug Brand Names

Risperidone • Risperdal Zolpidem • Ambien

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Clinical Point

Spiritual care professionals may provide comfort and support, and help patients connect to a religious or spiritual community

Bottom Line

Delusions with religious content are associated with poor outcomes, including dangerousness to self or others. Comprehensive evaluation and treatment plans that incorporate psychosocial and spiritual dimensions, which might include enlisting the help of a spiritual care professional such as a chaplain or clergy, may improve assessment and care.