International Psychogeriatrics (2024), 36:1, 21–23 © International Psychogeriatric Association 2022
doi:10.1017/S1041610222000369

COMMENTARY

Religious delusions, psychosis, and existential meaning in later life

Christopher C.H. Cook[1] and Rachel J. Cullinan[2]

[1]*Institute for Medical Humanities, Durham University, Durham, UK, E-mail: c.c.h.cook@durham.ac.uk*
[2]*Cumbria, Northumberland, Tyne & Wear NHS Trust, Newcastle, UK*

The psychopathologies and transitions of later life present challenges to core aspects of being, including those concerns that might best be described as spiritual: the personal vision of life, relationships, and meaning (Head *et al.*, 2023). On the other hand, spirituality and religion are positively related to well-being in later life (Wink and Dillon, 2003) and play an important part in dealing with the losses associated with declining health (Shaw *et al.*, 2016). There is thus a complex and bidirectional relationship between spirituality and religion on the one hand, and the challenges of aging and illness on the other hand. The integration of spirituality into the care of older adults may be beneficial, not least because of its relevance to coping, well-being, and the building of positive therapeutic relationships (Peteet *et al.*, 2019).

In this issue of *International Psychogeriatrics*, Annemarie Noort and her colleagues have shown that, in a Dutch sample of older adults receiving treatment for psychosis, patients with religious delusions were statistically more likely to employ positive religious coping and less likely to employ negative religious coping, compared to patients without religious delusions. One might have expected that this would predict a better outcome except that, in some studies, religious delusions have been associated with poorer outcome. The relationships between coping and outcome are therefore complex (Mohr *et al.*, 2010) and it is perhaps not surprising that, in the study by Noort *et al.* (2022), religious delusions did not predict overall outcome as measured by reduction of symptoms of psychosis. However, in patients with a depressive psychosis, religious delusions predicted a less favorable course over time as measured by depressive symptoms.

As in previous research from the same group (Noort *et al.*, 2020), religious delusions were more frequently observed in patients who were either strict protestants or Roman Catholics. Religious background and affiliation thus appear to influence symptom formation on the one hand and coping on the other hand. We might, in a general sense, say that religion tended to be more important for these patients, although it is perhaps dogmatism as much as personal importance that may be the issue here (Noort *et al.*, 2020). Research conducted by Mohr *et al.* (2010) also suggests that patients with religious delusions may get less support from their religious communities. Sadly, it would therefore appear that the very people for whom religion is most important, and who experience religious delusions in the course of psychosis, are also the ones who receive less support from their faith communities. The benefits of positive religious coping may therefore simply be negated by the negative impact of lack of support from other members of the faith community.

The study by Noort *et al.* is particularly important by virtue of its prospective design and thus is able to show that religious delusions experienced in the course of a depressive psychosis usually decline over the course of a 12-month follow-up period and, during the same period, depressive symptoms also improve (although less so in patients with religious delusions than in those without). The same improvements are not experienced by patients with schizophrenia, for whom religious delusions appear to be particularly persistent. Whereas we may find some reason to hope that the former group can experience reintegration into their church communities, it would appear likely that the latter group will continue to experience exclusion.

The present study extends findings from the same research group, in the same sample (Noort *et al.*, 2018, Noort *et al.*, 2020), by way of providing data from a 12-month follow-up. Research on spirituality/religion in psychiatry has far too often relied on cross-sectional samples, and this development adds significantly to our understanding of how psychopathology develops in relation to religiosity over time. We know from the previous studies that religious delusions are relatively common in this group of older patients, being found in 47% of those with psychotic depression and 32% of those with schizophrenia (Noort *et al.*, 2018). Figures for religious hallucinations were somewhat lower (9.4%

and 17.5%, respectively) (Noort *et al.*, 2020). Religious delusions in this sample appear to be associated with severity and complexity of psychosis and are in turn apparently related to existential concerns (Noort *et al.*, 2018). The study reported in this issue of *International Psychogeriatrics* begins to give us a picture of how they influence the course of psychosis over time. In depressive psychosis, the picture is one of slower recovery of mood, but with a relatively rapid decline in delusions that may in turn favor positive religious coping. In schizophrenia, the picture is altogether different, with persistence of beliefs that may make it difficult to find support from within the church communities that are so important to these Christians.

Further research will be required to better understand how religiosity, religious coping, and course of illness relate over time. Meanwhile, we are left to reflect on exactly how spirituality/religion might better be integrated into treatment in a group of patients such as this one. One important consideration may be that of the need to overcome the epistemic injustice associated with a diagnosis of a psychotic disorder both in churches and in mental health services (Swinton, 2020, pp.145–147). Patients who are deluded are less likely to be taken seriously when it comes to discussions of faith, meaning, and spirituality. Their statements about such matters are more likely to be taken as indicators of illness. The prejudices that operate to generate epistemic injustice thus also deprive patients with religious delusions of their need to be taken seriously when discussing the things that matter most to them and, indirectly, of the benefits of some of the forms of positive religious coping that could potentially facilitate their recovery. Overcoming epistemic injustice may not be easy and may require changes to medical education, as well as the giving of more attention by clinicians to subjective and existential concerns of their patients (Crichton *et al.*, 2017), including those related to spirituality and religion.

A second way in which spirituality/religion may better be integrated into treatment is by means of interventions aimed at improving religious coping. In the present study, patients already seemed to be good at positive religious coping and employed relatively less negative religious coping. However, these are strengths that can be built upon, and it is not clear from the data presented whether the different forms of religious coping increase or decrease during follow-up. The authors give examples in their text of significant forms of negative religious coping that are potentially harmful, such as beliefs about the influence of the devil, feeling abandoned by God, and beliefs about sin, guilt, and punishment. To use the terminology of Pargament and Exline (2022), these represent moral struggles, divine struggles, and demonic struggles. The Dutch version of the Brief Religious Coping Scale used in this study included only four items on negative religious coping, and these items focus on divine struggles and struggles with doubt, leaving open the possibility that other forms of negative religious coping may in fact be a significant problem for this group of patients. For example, we might imagine that demonic struggles and interpersonal struggles could be a significant challenge for patients with religious delusions. Pargament and Exline have explored various ways of working with spiritual struggles (i.e. negative religious coping) in psychotherapy that might be particularly helpful for these patients.

Finally, whilst as clinicians we recognize the importance of improving our own abilities to assess and discuss these topics with patients, we must also be mindful of our limits and boundaries. Koenig (2013) describes chaplains as the true spiritual care specialists. He highlights that health professionals have a key role in identifying and assessing spiritual needs in relation to the health of their patients but argues that they are not best placed to address them. For the patients discussed in this paper, for whom their illness incorporated religious delusions, the boundaries between health and spiritual care needs are more complicated and "blurred." Thus, offering these patients chaplain support and involving religious and/or spiritual leaders in their care and management is even more important.

Peteet *et al.* (2019) describe how to integrate spirituality into the care of older adults with early assessment of these needs by treating clinicians followed by referral to trained spiritual caregivers or the relevant spiritual healer for that patient. They accept that there may be situations with simple spiritual needs that a clinician may feel able to address; however, they are clear that everything else should be referred for spiritual support. They suggest one of the best ways to organize and help to make these decisions is with a small spiritual care team consisting of the physician/therapist, a spiritual care coordinator, and clinic receptionist, as described by Koenig (2014). The evidence base they cite for these practices is limited but so far promising.

The model (and terminology) that Koenig and Peteet describe will clearly need to be modified in different international contexts. In the NHS, in the UK, the "spiritual care team" refers to what other hospitals might call the chaplaincy department and is not usually (if ever) the integrated and multi-professional team that Koenig and Peteet *et al.* propose. Availability of chaplains varies from one hospital to another, and there are different

https://doi.org/10.1017/S1041610222000369 Published online by Cambridge University Press

understandings of what chaplains – or spiritual care teams – should properly offer, and sometimes greater barriers to information sharing across professional boundaries. Other models of integration of spirituality into healthcare have included the development of a multidisciplinary spirituality working group to promote good practice (Cook *et al.*, 2012) and attempts to "bridge the gap" between healthcare and local faith communities (Bunker, 2019).

Mental healthcare, not least amongst the elderly and those with religious delusions, needs to find better ways of integrating spiritual and existential concerns within a multifaceted approach to helping patients find meaning amidst their experiences of illness. Noort *et al.* have helped us to better understand some of the challenges that this entails.

Conflict of interest

There are no conflicts of interest to declare.

References

Bunker, N. (2019). Bridging the gap. The interface between NHS care and faith communities. In: J. Fletcher (Ed.), *Chaplaincy and spiritual care in mental health settings* (pp. 57–67). London: Jessica Kingsley.

Cook, C. C. H., Breckon, J., Jay, C., Renwick, L. and Walker, P. (2012). Pathway to accommodate patients' spiritual needs. *Nursing Management*, 19, 33–37.

Crichton, P., Carel, H. and Kidd, I. J. (2017). Epistemic injustice in psychiatry. *BJPsych Bull*, 41, 65–70.

Head, J. H., Lawrence, R. M. and Cullinan, R. J. (2023). Ageing. In: C. C. H. Cook and A. Powell (Eds.), *Spirituality & psychiatry*. Cambridge: Cambridge University Press.

Koenig, H. G. (2013). *Spirituality in Patient Care: Why, How, When, and What*. West Conshohocken, PA: Templeton.

Koenig, H. G. (2014). The spiritual care team: enabling the practice of whole person medicine. *Religions*, 5, 1161–1174.

Mohr, S., Borras, L., Betrisey, C., Brandt, P.-Y., Gilliéron, C. and Huguelet, P. (2010). Delusions with religious content in patients with psychosis: how they interact with spiritual coping. *Psychiatry*, 73, 158–172.

Noort, A., Beekman, A. T. F. and Braam, A. W. (2020). Religious hallucinations and religious delusions among older adults in treatment for psychosis in the Netherlands. *Religions*, 11, 522.

Noort, A., Beekman, A. T. F., Van Gool, A. R. and Braam, A. W. (2018). Religious delusions in older adults: diagnoses, combinations, and delusional characteristics. *International Journal of Geriatric Psychiatry*, 33, 1680–1687.

Noort, A., Braam, A., Koolen, J. and Beekman, A. (2022). Religious delusions in Dutch older adults in treatment for pyschosis: a follow-up study. *International Pyschogeriatrics*, https://doi.org/10.1017/S1041610222000102.

Pargament, K. I. and Exline, J. J. (2022). *Working with spiritual struggles in psychotherapy: from research to practice*. New York: Guilford Press.

Peteet, J. R., Zaben, F. A. and Koenig, H. G. (2019). Integrating spirituality into the care of older adults. *International Psychogeriatrics*, 31, 31–38.

Shaw, R., Gullifer, J. and Wood, K. (2016). Religion and spirituality: a qualitative study of older adults. *Ageing International*, 41, 311–330.

Swinton, J. (2020). *Finding Jesus in the Storm: The Spiritual Lives of Christians with Mental Health Challenges*. Grand Rapids: Eerdmans.

Wink, P. and Dillon, M. (2003). Religiousness, spirituality, and psychosocial functioning in late adulthood: findings from a longitudinal study. *Psychology and Aging*, 18, 916–924.

https://doi.org/10.1017/S1041610222000369 Published online by Cambridge University Press