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THE RELATIONSHIP BETWEEN RELIGIOUS EDUCATION AND RELIGIOUS DELUSIONS IN PATIENTS WITH SCHIZOPHRENIA: A CROSS-SECTIONAL STUDY

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ABSTRACT

The prevalence of religious-themed delusional thinking among individuals with schizophrenia varies significantly across different countries and cultural contexts. Despite the relevance of this phenomenon, in-depth studies focusing on religious delusions within Islamic contexts remain scarce. To gain a deeper understanding of psychotic symptoms involving religious content, this study investigates the potential relationship between religious education and the manifestation of religious delusions.This study aims to explore the association between religious education and the occurrence of religious delusions in patients diagnosed with schizophrenia. A quantitative, correlational research design was employed using a cross-sectional approach. A total of 127 participants were recruited through total sampling, all of whom met the established inclusion criteria. Data collection was conducted over a two-month period using structured interviews and five assessment tools: a sociodemographic questionnaire, the Scale for the Assessment of Positive Symptoms (SAPS), a Religious Delusion Algorithm, the Peters Delusions Inventory (PDI), and the Brown Assessment of Beliefs Scale (BABS). Data were analyzed through univariate, bivariate, and multivariate logistic regression analyses. The results indicate a significant relationship between religious education and the presence of religious delusions, as evidenced by the logistic regression analysis (OR = 30.85, 95% CI [6.027, 157.92]).Conclusion: This study concludes that there is a relationship between religious education and the occurrence of religious delusions in individuals with schizophrenia. These findings highlight the importance of considering a patient's religious background in the diagnostic and therapeutic approach to psychotic disorders involving religious content.

INTRODUCTION

Mental and emotional health are fundamental aspects of every individual's life, as they play a significant role in shaping overall quality of life. Good mental health enables a person to cope with life's pressures, work productively, and contribute positively to their

community. It is an essential foundation for personal well-being and societal harmony. Mentally healthy individuals are capable of managing stress, maintaining harmonious interpersonal relationships, and sustaining stable self-confidence. This indicates that mental health is not merely the absence of mental disorders, but also encompasses the ability to grow psychologically and emotionally, adapt to changes, and experience a sense of purpose and fulfillment in life.

Conversely, when mental health is compromised, individuals may face difficulties in social interactions, decreased productivity, and even a loss of functional capacity in daily life. This can lead to a downward spiral where the individual becomes increasingly isolated, disconnected from others, and may develop further psychological issues, contributing to a reduced quality of life. Mental health disorders often go beyond the personal suffering of the individual; they also affect families, communities, and economies, further emphasizing the importance of early detection and effective intervention. One of the most severe and often stigmatized mental disorders is schizophrenia, a chronic and complex mental illness that affects an individual's thinking, emotional regulation, and behavior.

Schizophrenia is not only a medical condition but also a social and psychological challenge that requires interdisciplinary attention, particularly in the fields of nursing, psychiatry, and public health. It poses unique challenges in diagnosis, treatment, and care, particularly in different cultural contexts. According to the World Health Organization (WHO, 2017), approximately 25 million people globally are affected by schizophrenia, and in Indonesia, the estimated number reaches 2.6 million. The Basic Health Research (Riskesdas, 2018) also reports that more than 400,000 Indonesians suffer from severe mental disorders, including schizophrenia. These figures highlight the substantial burden placed on individuals, families, and healthcare systems in addressing this condition. It is not just a mental health issue, but a public health concern that calls for improved access to care, comprehensive treatment models, and widespread awareness to reduce stigma and improve outcomes.

The symptoms of schizophrenia are generally divided into two main categories: negative symptoms and positive symptoms. Negative symptoms include reduced social and emotional functioning, such as apathy, lack of motivation, and impaired emotional expression. These symptoms can often be more disabling than the positive symptoms, as they can lead to a lack of engagement with the world, making it difficult for individuals to maintain relationships or participate in daily activities. Positive symptoms, on the other

hand, include hallucinations (false perceptions of reality) and delusions (strongly held false beliefs). These are the more visible symptoms that typically lead individuals to seek help, as they can create significant disruptions in an individual's ability to function. One of the most prominent and complex symptoms is delusion, which is often an indicator of relapse and a major obstacle in the recovery process.

Religious delusion is a specific type of delusion frequently observed in patients with schizophrenia. It typically involves extreme religious beliefs or distorted interpretations of religious values, often resulting in the person becoming convinced of a divine mission or special status within their religious community. For instance, a patient may believe they are a prophet, a divine figure, or a messenger of God, despite having no evidence to support such beliefs. These delusions can be highly elaborate and may lead to social isolation or dangerous behavior, especially if the individual feels compelled to act on their beliefs. Research has shown that patients experiencing religious delusions often present with more severe symptoms, are more challenging to treat, and usually require higher doses of medication (Siddle et al., 2002). In such cases, the therapeutic approach may need to be adjusted to address both the psychiatric needs and the religious content of the delusions, as ignoring the religious aspect may hinder treatment progress.

Interestingly, the level of religiosity in a society may influence the types of delusions experienced by patients. In several cases, religious delusions are more commonly found in communities with strong religious backgrounds, such as highly devout Protestant or Catholic groups (Noort et al., 2020). In these communities, individuals with schizophrenia may develop delusions that align with the dominant religious themes or figures in their culture. Anderson et al. (2018) further suggest that unstructured spirituality and incomplete understanding of religious teachings can contribute to the emergence of religious delusions, especially when individuals are under significant psychological stress. This highlights the complex interplay between culture, religion, and mental illness, and underscores the need for a nuanced approach in the treatment of patients with religious delusions.

Nevertheless, research on religious delusions within the Indonesian cultural context remains very limited, particularly in areas with high levels of religiosity such as Aceh. Considering Indonesia's rich religious and cultural diversity, the country offers a highly relevant setting for further exploration of this phenomenon. The diverse religious backgrounds in Indonesia, combined with the unique local practices and beliefs, make it essential to understand how these factors influence the manifestation of religious

delusions. Specifically, in Aceh—where religious education is a central aspect of daily life—it is crucial to understand the relationship between religious context and psychotic symptoms, as this can provide valuable insights for mental health practitioners working in the region.

The lack of local research creates a gap in data, which hinders the development of contextual and culturally sensitive nursing interventions. Understanding the role of local religious beliefs and cultural practices in the development of mental health conditions like schizophrenia can significantly enhance the efficacy of interventions. In fact, interventions that incorporate local religious and cultural values are likely to be far more effective in supporting the recovery of patients with schizophrenia, particularly those experiencing religious delusions. By acknowledging and respecting the religious context of patients, mental health professionals can create a more personalized and effective treatment plan that resonates with the patient's worldview.

Factors such as age, gender, duration of illness, education level, occupation, marital status, place of residence, and the length of untreated psychosis have all been shown to significantly correlate with the occurrence of delusions (Siddle et al., 2018). These factors can act as both risk factors and protective factors, depending on the individual's situation. Furthermore, in some cultures, extreme spiritual experiences or beliefs in supernatural possession may complicate the diagnosis and treatment of religious delusions. This cultural complexity necessitates a more integrated approach to mental health care, one that combines psychiatric expertise with cultural sensitivity.

Therefore, it is essential to encourage more interdisciplinary research that examines the relationship between religious background, socio-cultural conditions, and the manifestation of delusions—particularly within the context of Muslim communities in Indonesia. Such efforts will allow mental health nursing services to be more effectively tailored to the needs and values of the populations they serve. This will contribute to a more holistic approach in the treatment of schizophrenia and other mental health conditions, ultimately improving patient outcomes and enhancing the overall quality of mental health care.

RESEARCH METHODS

This study employed a quantitative correlational design with a cross-sectional approach to explore the relationship between religious education and the occurrence of religious delusions in individuals diagnosed with schizophrenia. The primary objective

was to examine how religious education, as the independent variable, influences the emergence of both religious and non-religious delusions, which were the dependent variables. This approach allowed for a snapshot of the existing conditions at a specific point in time, facilitating the identification of potential associations between educational background and delusional experiences in a population of schizophrenia patients.

The study began with a screening process to identify patients diagnosed with schizophrenia who were exhibiting symptoms of delusions. A standardized instrument, the Scale for the Assessment of Positive Symptoms (SAPS), was used to assess the presence and severity of positive symptoms, specifically focusing on delusions. The SAPS scale provided a structured and reliable method for identifying individuals with delusions, which were the primary focus of this study. Following the initial screening, patients who were identified as having delusions were invited to participate in the study.

Once delusional patients were identified, the researchers conducted structured interviews to gather sociodemographic data such as age, gender, education level, and religious background. This information was crucial in understanding the broader context of the patient's life and how their educational experiences, particularly in religious settings, may have influenced their delusional beliefs. The patients were then assessed to determine whether their delusions were religious or non-religious. This classification was done using a set of questions aligned with the Religious Delusion Algorithm, a specialized tool used to differentiate between delusions of a religious nature and those with non-religious themes. The algorithm provided a systematic way to validate the diagnosis of religious delusions, ensuring the accuracy and consistency of the assessment process.

Following the initial assessment, further evaluations were conducted using the Peters Delusions Inventory (PDI). The PDI is a widely recognized instrument designed to assess the content and intensity of delusions, providing a deeper understanding of the nature of the delusions in question. The results from the PDI helped in categorizing the delusions more comprehensively, distinguishing between those that were religiously oriented and those that were not. After completing these three primary assessment tools, patients with identified delusions were subjected to an additional round of structured interviews using the Brown Assessment of Beliefs Scale (BABS). This scale was used to evaluate the strength and nature of the delusional beliefs, offering insights into the patient's conviction and emotional attachment to their delusions.

The study population consisted of all patients diagnosed with schizophrenia who were admitted to the inpatient wards of Aceh Mental Hospital. To ensure a representative sample, the study employed a non-probability sampling technique, specifically purposive sampling, which is commonly used in clinical research when the researcher aims to select participants based on specific characteristics or conditions relevant to the study. In this case, participants were selected based on their diagnosis of schizophrenia and the presence of delusions.

Data analysis was performed using a combination of univariate, bivariate, and multivariate methods, with a particular focus on logistic regression analysis. This approach allowed for the examination of the relationships between various variables, including the influence of religious education on the occurrence of religious delusions. Univariate analysis was used to examine the frequency and distribution of individual variables, while bivariate analysis was employed to explore potential relationships between two variables at a time. Finally, multivariate analysis, including logistic regression, was utilized to assess the impact of multiple independent variables (such as religious education) on the likelihood of developing religious delusions, while controlling for confounding factors.

The sample selection was based on inclusion and exclusion criteria to ensure that the participants met the necessary requirements for the study. The inclusion criteria for the study were as follows: the patient must have been diagnosed with schizophrenia, must exhibit delusions (as indicated by a minimum score of 2 on any delusion item in the SAPS scale), and must be willing to participate in the study. The study excluded patients who were unable to provide informed consent, those with severe cognitive impairments, or those who did not meet the diagnostic criteria for schizophrenia.

In total, 258 patients were initially screened for participation. Of these, 127 patients were identified as meeting the criteria for delusions, either religious or non-religious, and were included in the study. The participants were predominantly Muslim, as the study focused on individuals from this religious background, although both male and female patients were included. These patients were receiving inpatient care in the acute, sub-acute, or intermediate care wards of Aceh Mental Hospital, reflecting a range of severity levels in their condition.

By employing this structured approach, the study aimed to provide a comprehensive analysis of the potential relationship between religious education and delusional beliefs in individuals with schizophrenia, while also considering

sociodemographic factors and the strength of their delusions. The results of this study could provide valuable insights into how specific educational environments may influence the development and progression of delusions in psychiatric patients, contributing to a deeper understanding of schizophrenia and its associated symptoms.

RESULTS AND DISCUSSION

Results

The results of the study conducted on 127 respondents and the frequency distribution of sociodemographic factors are as follows:

Table 1. Frequency Distribution of Sociodemographic Factors in Respondents with Delusions

No	*Sociodemographic Data*	*F Frequency*	*P Persentage*
1	J Gender		
	Male	109	85,8
	Female	18	14,2
2	Religious Education		
	Islamic Boarding School	73	57,5
	Non Islamic Boarding School	54	42,5

Based to Table 1, the majority of respondents are male, comprising 85.8%, and regarding religious education, 57.5% of the respondents have attended Islamic boarding schools (pesantren)

Table 2. Frequency Distribution of Religious and Non-religious Delusions Data

No	*Variable*	*Delucion*	
		Religious	**Non Religious**
1	Gender		
	Male	47 (43,1%)	62 (56,9)
	Female	6 (33,3%)	12 (66,7%)
2	Religious Education		
	Islamic Boarding School	46 (63,0%)	27 (37,0%)
	Non Islamic Boarding School	7 (13,2%)	47 (87,0%)

Based on Table 2, it can be seen that the most dominant gender is male, accounting for 43.1%, while in the category of religious education, 63.0% of respondents had attended Islamic boarding schools (pesantren).

To examine the relationship between each independent variable and the dependent variable, a Chi-square test was employed, with a significance level set at $p < 0.05$. The results of the Chi-square analysis are presented in Table 3 below:

Table 3. Analysis of the Relationship Pattern Between Sociodemographic Factors and Religious Delusions

No	*Variable*	*Chi -Square*	*P=Value*
1	Gender	0,608	0,435
2	Religious Education	31,977	0,001

Based on Table 3, there is a significant association between religious education and an increased occurrence of religious delusions in patients with schizophrenia (p = 0.001).

Table 4. Logistic Regression Results of Respondents at Aceh Mental Hospital

Variable	*Category*	*OR*	*95% CI*		*P-value*
			Lower	Upper	
Religious Education	Yes No	30.852	6.027	157.929	0,001

Based on Table 4, it can be concluded that the logistic regression results indicate that individuals with religious education have a 30.8 times higher likelihood of experiencing religious delusions compared to those who have not received religious education.

Discussion

The Relationship Between Religious Education and the Occurrence of Religious Delusions in Individuals with Schizophrenia:

Religious education refers to an educational system that emphasizes the learning of religious teachings, particularly Islam. In the Indonesian context, this is commonly manifested through Islamic boarding schools, known as pesantren. According to Zuhriy (2011), pesantren can be broadly categorized into two main types: salafi and khalafi pesantren. Salafi pesantren adopt a traditional learning system focusing on classical Islamic texts (kitab kuning) as their core curriculum, without incorporating secular subjects such as science, mathematics, or foreign languages. In contrast, khalafi pesantren, often referred to as modern pesantren, combine religious education with the national curriculum, including general subjects, making them more adaptive to contemporary educational needs.

Based on the findings of this study, 57.5% of patients exhibiting religious delusions had a background in religious education, either from salafi or khalafi pesantren. However, a review of existing literature revealed a paucity of research directly examining

the correlation between religious education in pesantren and the emergence of religious delusions, particularly within the Indonesian sociocultural context.

One relevant study was conducted by Hakiqi (2013), which reported that adolescents living in pesantren experienced higher levels of depression compared to those residing with their families. This suggests that a closed and highly structured educational environment, such as that of a pesantren, may act as a significant stressor. Similarly, Wahab et al. (2013) found that students in boarding schools exhibited high prevalence rates of psychological disorders: 39.7% for depression, 67.1% for anxiety, and 44.9% for stress. Contributing stressors included academic pressure, poor interpersonal relationships, intrapersonal conflict, relationships with teachers, teaching methods, and social class dynamics within the pesantren environment.

These findings lead the authors to propose that the onset of religious delusions in some patients at the Aceh Mental Hospital may be influenced by experiences of depression or psychological pressure encountered during their time in religious educational settings. Such stress may stem from drastic environmental changes, social isolation, or unrealistic familial expectations regarding academic and spiritual achievements. When these expectations are unmet, individuals with low psychological resilience and poor coping mechanisms may develop psychological disturbances that manifest as psychotic symptoms, including religious delusions.

This study also found that many respondents had previously received formal education at the junior secondary level before discontinuing and transitioning into salafi or khalafi pesantren. This educational transition, accompanied by a shift in environment and lifestyle, may constitute a unique psychosocial stressor that contributes to mental health issues.

Another noteworthy finding is that patients with pesantren backgrounds tended to express religious delusions that were both highly elaborate and spiritually charged. Some patients claimed to be prominent religious figures such as ustadz, scholars, the Mahdi, prophets, or angels, and even professed to have received divine revelations from God to save the people of Aceh from catastrophes such as tsunamis. Others believed themselves to be memorizers of the Qur'an, translators of the Bible, Torah, and Psalms, or authors of scholarly works on tawhid and ma’rifat. This diversity in delusional content suggests that personal factors strongly influence the form and substance of the delusions experienced by patients.

These findings differ from research by Gearing et al. (2011), which showed that delusional content in patients with schizophrenia typically involved more general religious themes, such as prayer, guilt, possession, or religious figures like God, Jesus, Satan, and prophets. Similarly, Atallah et al. (2001), in a study of 632 psychotic patients in Egypt (predominantly Muslim), found that the most common religious delusions involved God (36%), Satan (14%), sheikhs/imams (12%), Jesus (11%), Prophet Muhammad (9%), as well as jinn, angels, saints, the Day of Judgment, and the Antichrist (Dajjal)—all of which are embedded in the religious narratives of the Qur'an. These variations in delusional content are likely rooted in the patients' respective religious and cultural backgrounds (Ryan et al., 2020).

Furthermore, Gearing (2011) noted that Christian patients exhibited higher frequencies of religious delusions, particularly those involving guilt and sin, compared to adherents of other religions. Ventriglio (2018) reinforced this finding, indicating that Christians are more prone to grandiose delusions related to guilt and sin than Muslim or non-religious patients. Gearing also observed that delusions involving persecution by supernatural beings were more commonly found in non-Muslim patients than in Muslim or Buddhist ones.

Interviews conducted as part of this study revealed that some patients felt burdened by their families' expectations for academic success. When these expectations were unmet, the resulting internal conflict and psychological pressure appeared to evolve into religious delusions, through which patients sought meaning, recognition, or escapism by constructing a delusional spiritual identity.

However, it is crucial to emphasize that religious education alone is not a direct cause of religious delusions. Rather, these delusions emerge from a confluence of interpersonal, psychological, social, and spiritual factors. Individuals with weak coping mechanisms, high environmental stress, and unrealistic expectations are more vulnerable to developing such delusional symptoms.

Therefore, a multidisciplinary approach is needed to treat patients presenting with religious delusions, especially those with a pesantren background. This approach must be sensitive to spiritual aspects while prioritizing evidence-based psychological and psychiatric interventions. Further research is also necessary to explore the complex relationships between religious education, mental health, and the development of delusions, so that future interventions can be more targeted and contextually appropriate.

CONCLUSION AND SUGGESTIONS

There is a significant correlation between religious education and the emergence of religious delusions in patients diagnosed with schizophrenia at Aceh Mental Hospital. This association suggests that certain educational backgrounds, particularly those in religious settings, may contribute to the onset or exacerbation of religious delusions. However, the complexity of the factors involved indicates that a broader understanding is needed to unravel the underlying mechanisms.

Future researchers are strongly encouraged to explore this topic further by employing a variety of research designs, particularly qualitative methods, which could provide a more nuanced and comprehensive understanding of the progression of religious delusions in individuals with schizophrenia. Qualitative approaches, such as in-depth interviews and case studies, would allow for a more subjective and personal exploration of how religious experiences, educational environments, and psychological pressures intersect in these patients' lives.

Moreover, it is important to focus on obtaining detailed, first-hand accounts from patients, as this would offer valuable insight into their lived experiences and the emotional and cognitive processes that may contribute to the development of religious delusions. This could enhance our understanding of the dominant factors identified in this study, including the role of family expectations, social isolation, and the specific educational environments of pesantren (Islamic boarding schools).

Further studies should also consider a broader population sample that includes individuals from various educational and religious backgrounds, to determine whether these findings hold true across different cultural contexts and religious traditions. By examining a more diverse group of patients, future research can better inform the development of targeted psychological and therapeutic interventions, which would be essential for managing and preventing religious delusions in individuals with schizophrenia.

In conclusion, exploring the relationship between religious education and religious delusions through more comprehensive and varied research methods will help build a more robust understanding of the factors contributing to psychotic symptoms, ultimately improving the quality of care for affected individuals.

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