

## The Spiritual-Religious Support in Patients with Schizophrenia

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### Abstract

**Aim:** To examine the influence of spiritual-religious support in schizophrenia patients on the experience of God, superstition, and illness.

**Methods:** The research was conducted from January 2021 to December 2022 on 117 patients with schizophrenia during a two-month treatment period. A self-assessment questionnaire examined the subjective experiences of God, superstition, and illness. The trial was conducted at hospital admission and after two months of integrative psychiatric treatment with spiritual-religious support.

**Results:** There was no statistically significant difference in belief in the existence of God after treatment versus responses at admission (62% vs 75%,  $P=0.05$ ). There was also no significant statistical difference in admission in the inquiry's results about what kind of God the respondents believed in ( $P=0.51$ ). Compared to admission, statistically significantly fewer respondents are superstitious ( $P = 0.02$ ), and statistically fewer respondents are perceived as sick (41% vs. 58.1%,  $P = 0.001$ ).

**Conclusion:** Spiritual-religious support for patients with schizophrenia helps with spiritual questions and religious doubts, contributes to belief in God as a benevolent higher power, and reduces beliefs in the influence of a negative higher power as the cause of illness and personal impotence. It is one way of psychological intervention towards more adequate thought processes and contributes to recovery from the disease.

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## Introduction

Schizophrenia is a severe mental disorder that affects a large number of people around the world. According to the World Health Organization, about 24 million people suffer from this disease, which is about 0.32% of the total world population(1).

It seems that schizophrenia is not a single disease, but a whole spectrum of disorders with abnormalities in the perception of reality, thinking, emotions, and behavior. Although the exact cause of this disorder is unknown, various studies show that this is a disorder of complex etiology and pathophysiology, dependent on many psychological, biological, and environmental factors(2). The disorder itself can differ significantly among patients in terms of which symptoms prevail in the clinical picture. Common signs and symptoms are affect disorder, hallucinations, delusions, impaired cognitive abilities, speech and behavioral disorder, and a tendency to social withdrawal. The disease itself affects many psychological functions and different spheres of human functioning, including experiences of religiosity and spirituality, regardless of religious affiliation and cultural environment(3).

The term religiosity represents an individual's commitment to religious beliefs, principles, and activities, while the term spirituality represents an abstract experience that is closely related to religiosity and refers to one's own experience of the sacred and transcendental, regardless of belonging to a particular formal religious institution(4).

Spirituality and religiosity are very important in the lives of many people, including many people with schizophrenia. They have a significant influence on various psychological features, including cognition, motivation, experience, and behavior, but they can also contribute to unhealthy content in thoughts, perception, and emotional experience. Previous research has shown a greater preoccupation with spiritual content in patients who have schizophrenia, a higher degree of religiosity than in the general population, and an important role of spiritual-

religious support in the course of the disease and treatment outcomes(5).

Treatment of schizophrenia requires therapeutic strategies that include drugs, primarily antipsychotics, but also additional symptomatic therapy, psychoeducation, family interventions, psychotherapy, and psychosocial rehabilitation(2). In the Special Hospital for Psychiatry and Palliative Care „Sveti Rafael“ in Šumetlica, the aforementioned therapeutic procedures and spiritual-religious support are carried out, which is a form of religious coping that can be positive and negative.

Positive religious coping is a psychological intervention whose goal is to assign meaning to life's challenges and provide a sense of meaning and comfort. During positive religious coping, strengthening control over one's actions and more active involvement in the spiritual community are encouraged, and positive faith in God as a benevolent higher power is strengthened. Negative religious coping seeks to remove belief in the influence of malicious force majeure, superstition, and separation from the religious community. It aims to encourage a person to accept their condition as a challenge leading to positive spiritual transformation, and it removes the interpretation of illness as a punishment for possible mistakes during life(6).

By ensuring comprehensive care for people with schizophrenia and their families and caregivers, using a recovery-oriented approach, better results are achieved in functioning and involvement in the community, which is extremely important in supporting patients(7).

Despite today's numerous therapeutic possibilities, people with schizophrenia still have a significantly shorter average life expectancy of up to twenty years compared to the general population. The shortening of life expectancy is the result of frequent comorbid conditions that occur with schizophrenia and a significant suicide rate among these patients(8). It is known that 4.9% of people diagnosed with schizophrenia die due to suicide, while the overall suicide rate in the general population is 1.3%(9). Spiritual-religious empowerment is crucial in the prevention of suicide due to the

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strengthening of one's experience of oneself as part of a positive force of God and finding the meaning of life, but also the judgmental attitude of most world religions towards the deliberate taking of one's own life. Better involvement in the community, a more correct experience of spirituality, religiosity, and one's illness contribute to a better quality of life and functioning of people who have schizophrenia(10,11).

## Participants and Methods

The research was conducted from January 2021 to December 2022. It included 117 patients who had schizophrenia at the Special Hospital for Psychiatry and Palliative Care „Sveti Rafael“ in Šmetlica during treatment lasting two months. Before starting the research, we received the approval of the ethics committee of the Special Hospital for Psychiatry and Palliative Care „Sveti Rafael“ and signed informed consent for each patient. The research was conducted following the ethical principles of the Declaration of Helsinki from 2000 and its amendments from 2002 and 2004. All patients could make informed decisions and could voluntarily participate or abandon the research at any time.

This research aimed to examine the influence of spiritual-religious support during integrative psychiatric treatment in schizophrenia patients on the experience of God as a benevolent higher power, superstition, and one's illness.

For this research, a self-assessment questionnaire was used, which is commonly used in the Special Hospital for Psychiatry and Palliative Care „Sveti Rafael“ in Šmetlica, for the evaluation of therapeutic effects, given that spiritual-religious support is an integral part of treatment in this hospital.

The questionnaire consists of two parts: a general, sociodemographic part and a structured part that examines the subjective experience of God, superstition, and one's illness.

The general sociodemographic section of the questionnaire contains queries on sex, marital status, offspring, place of residence, number of household members, religion, level of education, employment status, psychiatric heredity, including heredity for suicide. The questionnaire also included a query about the patient's suicidal attempts, that is, about the number of suicidal attempts so far. The general and sociodemographic characteristics of the subjects are shown in Table 1.

**Table 1. General and sociodemographic characteristics of the patients**

	Number of patients	(%)
<b>Gender</b>		
Men	51	(43.6)
Women	66	(56.4)
<b>Marital status</b>		
Married or cohabiting	22	(18.8)
Single	76	(65.0)
Divorced	14	(12.0)
Widower/widow	3	(2.6)
Unanswered	2	(2.6)
<b>Have children</b>	33	(28.7)
<b>Place of residence</b>		
City	71	(60.7)
Village	29	(24.8)
Suburban settlement	15	(12.8)
Unanswered	2	(1.7)
<b>Who lives with them?</b>		
Alone	28	(23.9)
Within community	81	(69.2)
Unanswered	8	(6.8)
<b>Religion</b>		
Catholic	102	(87.1)
Member of another religion	7	(6.0)
Atheist/agnostic	7	(6.0)
Unanswered	1	(0.9)

51 (43.6%) men and 66 (56.4%) women participated in the research. The median age of the patient is 39 years (interquartile range from 32 to 47 years), in the range from 19 to a maximum of 67 years. Concerning marital status,

76 (65 %) patients were single/unmarried. 33 (28.7 %) patients have children, with a median of 2 children (interquartile range from one to 3 children), ranging from one to a maximum of five children. 71 (60.7%) patients live in the city, and 81 (69.2%) live in the community. According to their religious affiliation, 102 (87.1%) patients state that they are Catholic.

**Table 2. Distribution of patients according to level of education and employment status**

	Number	(%)	of
	patients		
<b>Education level</b>			
Higher education and more	13	(11.1)	
Higher education	7	(6.0)	
Secondary education	77	(65.8)	
Elementary school	19	(16.2)	
Unanswered	1	(0.9)	
<b>Working status</b>			
Employed	33	(28.2)	
Unemployed	56	(47.9)	
Retired	23	(19.7)	
Student	2	(1.7)	
Undeclared work	3	(2.6)	

Table 2 shows the distribution of patients according to level of education and employment status. There are 77 (65.8%) patients with secondary education, and 13 (11.1%) with higher education. 56 (47.9%) patients are

unemployed, 33 (28.2%) are employed, and there are two students (1.7%).

Psychiatric status and psychiatric heredity are shown in Table 3. Psychiatric heredity in the family is recorded in 62 (53 %) patients. The median duration of treatment for patients is 10 years to a maximum of 41 years, and the median number of previous hospitalizations due to mental illness is 4, ranging from one hospitalization to a maximum of 30 hospitalizations. In the family, in 23 (19.7 %) cases, there was a suicide attempt, while 35 (29.9 %) patients had their suicide attempt, and that was the median twice, at least once, up to a maximum of 10 times.

The structured questionnaire assessed the subjective experience of God, superstition, and illness on two occasions, i.e., at admission and after two months of therapy. The respondents evaluated their knowledge of God through three basic parts, which include questions about the existence of God and their beliefs about what God is like. For the question of what kind of God they could answer to believe in, the authoritative, merciful, critical, or distant.

Superstition was assessed through a query about whether respondents believed astrologers, palm readers, tarot card readers, and fortune tellers could predict the future. At the same time, possible answers were yes or no. The subjective feeling of the disease was assessed by asking whether they felt sick, and the subjects could answer yes or no.

**Table 3. Patients according to psychiatric status and psychiatric heredity**

Psychiatric heredity in the family- n (%)	62 (53)
Duration of psychiatric treatment – years [Median (range)]	10 (5 – 20)
Number of hospitalizations due to mental illness – Median (range)	4 (2 – 8)
Attempted suicide in the family (%)	23 (19.7)
Attempted suicide of patient-n (%)	35 (29.9)
Number of suicide attempts of patient-n = 35 [Median (range)]	2 (1 – 3)

Not all respondents answered some of the questions. One hundred respondents

responded to the question about belief in the existence of God. Of the 75 respondents who stated that they believe in God, 73 of them responded to the question of what kind of God they believe in in more detail. Ninety-four respondents answered the question about superstition and predicting the future, while everyone responded to the question about their own experience of the disease, i.e., 117 respondents.

The McNemar-Bowker test was used to determine statistical significance, with statistical

significance  $p < 0.05$ . The statistical package IBM SPSS 25, manufactured in Chicago, United States of America, in 2017, was used for data processing.

## Results

The results of the research are shown in Table 4. Two months after the start of therapy, 75 (75 %) subjects did not doubt the existence of God compared to admission, when 62 (62%) subjects claimed that there was no doubt that God existed.

**Table 4. Distribution of patients according to subjective experience of God, superstition, and experience of illness at admission and after two months of therapy**

	Number (%) of patients		P
	At admission	After two months of therapy	
Existence of God (n = 100)			
I do not doubt that God exists	62 (62)	75 (75)	
I believe in a higher power or cosmic power	21 (21)	11 (11)	
I believe in God, but with some doubts	14 (14)	11 (11)	0.05
I don't believe in anything except the physical world	3 (3)	3 (3)	
I believe in God, who is (n = 73)			
Authoritative God	14 (19.2)	15 (20.5)	
Merciful God	46 (63)	49 (67.1)	
Critical God	6 (8.2)	3 (4.1)	0.51
Distant God	7 (9.6)	6 (8.2)	
Astrologers, palm readers, tarot card readers and fortune tellers can predict the future (n= 94)			
Yes	17 (18.1)	10 (10.6)	
No	77 (81.9)	84 (89.4)	<b>0.02</b>
Subjective assessment of the disease (n=117)			
Sick	68(58.1%)	48(41%)	<b>0.001</b>

**Bold denotes statistical significance**

After treatment, 11 (11%) respondents report believing in force majeure or believing in God, but with some doubts, while three (3%) respondents believe in nothing but the physical world. At reception, 21 (21%) respondents claimed to believe in a higher power or cosmic

power, 14 (14%) to believe in God, but with some doubts, and 3 (3%) to believe in nothing but the physical world.

Using the McNemar-Bowker test, with a statistical significance level of  $P < 0.05$ , we found

no statistically significant differences in responses about belief in God after treatment versus responses at admission.

Of a total of 73 (63.5 %) subjects two months after therapy who believe without a doubt that God exists, 15 (20.5 %) believe in a God who is authoritative, 49 (67.1 %) in a God who is merciful, three (4.1 %) respondents consider God critical, and 6 (8.2 %) distant, compared to admission when 14 (19.2%) believed in a God they experienced as authoritative 46 (63%) saw God as merciful, 6 (8.2%) as critical, and 7 (9.6%) as distant. Using the McNemar-Bowker test, with a statistical significance level of  $P < 0.05$ , we found no significant statistical differences in the type of God the subjects believed in at admission.

Statistically, significantly fewer subjects after two months of therapy believe that astrologers, palm readers, tarot card readers, and fortune tellers can predict the future (10.6 % vs. 18.1 %) (McNemar-Bowker test,  $P = 0.02$ ).

About the subjective assessment of the disease, 68 (58.1 %) subjects at admission stated that they were sick, and 48 (41 %) subjects after two months of integrative psychiatric treatment, with spiritual-religious support, which is a statistically significantly lower number of subjects who perceive themselves as sick after two months of admission (McNemar Bowker test,  $P = 0.001$ ).

## Discussion

In the treatment of schizophrenic patients, it is crucial to approach interdisciplinary observation, observing all biopsychosocial components, that is, applying the extended concept of person-centered treatment. Taking into account the human need for the spiritual and religious, we can understand man as a spiritual being and respect his need to solve spiritual questions related to his existence, meaning, and future, which is also an important factor in psychological recovery. This approach encompasses the integrative nature of psychiatric treatment and creativity, incorporating faith in God as a benevolent higher power and views man as a creature created in God's image, endowed with possibilities of

choice, freedom, responsibility, and openness to higher values in the pursuit and realization of his meaning. The goal of this approach in treatment is to provide a sense of meaning, comfort, and personal control, to strengthen faith in a benevolent higher power, and to remove the belief about the influence of a malicious higher power, superstition, and separation from the religious community(12).

Research similar to ours on the experience of God has been conducted on various religious groups worldwide. Our research stands out for its focus on members of the Catholic faith. Out of a total of 117 respondents, 102 (87.2%) answered that they belong to the Catholic faith, and 7 (6%) respondents declared that they belong to other religious groups. The other 7 (6%) declared themselves atheists and agnostics, and one (0.9%) did not answer this question. Among the 100 respondents who claimed to believe in God, initially 62 and after the spiritual-religious program, 75 did not doubt God's existence. From this, it can be concluded that even after the spiritual-religious support of 25 respondents, which is almost a quarter of the respondents out of the total number of 109 respondents who belong to a religious community, they only declaratively declare their religious affiliation, and this does not mean an unquestionable belief in God, which is very surprising. In a similar study of schizophrenic patients conducted by Triveni et al. in 2017 in India on 100 patients belonging to different religious groups, most of whom, or 69 (69%) of respondents, were Hindus, 99% of respondents said they believed in God(13).

In our study, after two months of spiritual-religious support, 75 patients no longer doubt God's existence, compared to 62 at admission, and 49 believe in a merciful God, up from 46 at admission. There is a smaller number of respondents who, after two months of spiritual-religious support, believe in a critical God (3, compared to 6 during admission) and a distant God (6, compared to 7 during admission). From this, it can be concluded that a smaller part of the respondents during the treatment accepted the belief in God through a spiritual-religious program as a benevolent higher power that accepts, understands, and forgives them, that is,

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they received a positive religious confrontation, but without statistical significance. Although, despite our spiritual-religious support, we did not find statistically significant changes in the experience of God, we believe, taking into account previous research, that spirituality and religiosity are intense internal experiences of an individual that are difficult to correct despite external intervention(14,15).

Most of the previous research, such as ours, also shows that a high proportion of patients with schizophrenia are religious. The more frequent use of religious confrontations in therapeutic processes is associated with a lower level of psychopathology and an improvement in the symptoms of the disease, as well as a lower experience of personal powerlessness(4,16).

Previous research also confirms that negative religious coping shows success in reducing symptoms of burdensome psychopathology of a spiritual character. The goal of negative religious coping as a psychological intervention is to correct cognitive distortions about believing in malicious force majeure, superstition, and understanding one's illness as punishment. Negative religious coping seeks to strengthen thought processes to return to a rational and logical level from the psychotic level of mystical and fantasy character, which manifests itself in the form of delusional thoughts and deceptions of the senses, which in the distant past was interpreted as the influence of malicious spirits, possession, or retribution of higher spiritual beings(17).

In Grover et al.'s research, conducted in 2021, compared to healthy controls, participants with any severe mental disorder, especially patients with schizophrenia, participated significantly less in organized religious activities and, during spiritual-religious support, more often needed negative religious coping(4). Many studies confirm that there is a need to include psychological interventions, such as negative religious coping, to solve burdensome religious and spiritual problems for people with various mental disorders(18).

Our research also showed a statistically significant reduction in superstition, as a result of

negative religious coping, in terms of psychological intervention towards more adequate thought processes and departures from the mystical way of thinking.

After two months of treatment, a significantly smaller number of subjects, 48 of them (41%), confirmed the subjective impression that they felt sick compared to the beginning of treatment, when 68 of them (58.1%) stated that they felt sick. Therefore, we conclude that spiritual-religious support as part of integrative treatment contributes to recovery as an additional supporting procedure in the integral biopsychosocial approach to treatment.

The importance of spiritual-religious support in reducing the feeling of illness is also emphasized in the prevention of suicide(19). A significant number of our subjects, 35 of them (30%), had at least one suicide attempt during their lifetime. During the research, we did not examine the predictors of suicidality, because during the treatment, all patients denied the existence of suicidal thoughts. The very existence of suicidal tendencies would be an exclusion factor from this integrative treatment, which is carried out in the Special Hospital for Psychiatry and Palliative Care in „Sveti Rafael“ in Šumetlica. Spiritual-religious support strengthens self-belief as part of a positive force majeure, reduces the limiting experience of one's illness, and encourages connection with one's religious community. And we can conclude that it also reduces the predictors of suicide associated with schizophrenia, such as feelings of powerlessness, worthlessness, and not belonging(20).

Observing religiosity and spirituality from a psychosocial point of view, research shows how different spiritual experiences are built from relationships with parents. In these relationships, the importance of love, support, and success in outgrowing traumatic experiences is indicated, whereby religion, spirituality, and social support have a positive impact on overall mental health outcomes(16). In the operation of life stories, religion plays an important, almost central role in the processes of experiencing oneself, one's own experience, and the meaning of life.

Sometimes religion can become part of psychological disturbances in the form of obsessive religious reflections, inadequate emotional experiences, and psychotic content in the form of religious delusions and deception of the senses. Such disturbed experiences of religiosity and spirituality require integrative psychiatric treatment with quality spiritual-religious support(21).

Patients are sometimes helped by their religious community. In such cases, they are accepted and destigmatized through their spiritual activities, which comfort and strengthen them. On the other hand, some patients are rejected by their insufficiently inclusive religious community, and such patients become demoralized and socially withdrawn. Spiritual-religious support in the form of religious coping is beneficial for the treatment of people with schizophrenia because it can help reduce psychopathology, encourage recovery, and inclusion in their spiritual community(22).

In accessing schizophrenic patients during spiritual-religious support, it is essential to tolerate differences, respect the beliefs of others, and exclude the possibility of aggressive recruitment towards a specific religious community, i.e., proselytism. It is good to have knowledge of one's own spiritual identity and to know the cultural features of both one's own and other religious communities(3).

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## Conclusion

Through our research, we found a statistically significant decline in superstition after spiritual-religious support as a result of negative religious coping. A statistically substantial subjective feeling of recovery was also recorded, which is especially important in the functioning of patients and the possible reduction of suicidal risk. Although some respondents experienced a shift in faith in God during spiritual-religious support, as a result of positive religious coping, we did not find statistical significance. This area remains interesting and open for future research.

Spiritual-religious support in the process of treating patients who have schizophrenia, along with integrative psychiatric procedures, helps to solve spiritual questions and religious doubts and contributes to the belief in God as a benevolent higher power. This kind of support reduces the belief in the influence of opposing force majeure as the cause of illness and personal impotence, which is undoubtedly one of the ways of psychological intervention towards more adequate thought processes and departures from the mystical way of thinking. The results of such interventions contribute to recovery from the disease and a lower sense of personal powerlessness.

## Disclosure

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**Competing interests.** None to declare.

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**Author contribution.**

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Analysis and interpretation of data: MŠ, VĐ, MJ  
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## Duhovno-religiozna podrška kod pacijenata sa shizofrenijom

### Sažetak

**Cilj:** Ispitati utjecaj duhovno-religijske podrške kod pacijenata sa shizofrenijom na iskustvo Boga, praznovjerja i bolesti.

**Metode:** Istraživanje je provedeno od siječnja 2021. do prosinca 2022. na 117 bolesnika sa shizofrenijom tijekom liječenja u trajanju od dva mjeseca. Upitnik za samoprocjenu ispitivao je subjektivno iskustvo Boga, praznovjerje i iskustvo bolesti. Ispitivanje je provedeno pri prijemu u bolnicu i nakon dva mjeseca integrativnog psihijatrijskog liječenja uz duhovno-religijsku podršku.

**Rezultati:** Nije bilo statistički značajne razlike u vjerovanju u postojanje Boga nakon liječenja u odnosu na odgovore pri prijemu (62% naspram 75%,  $P=0.05$ ). Također nije bilo značajne statističke razlike rezultatima ispitivanja o tome u kakvog Boga ispitanici vjeruju ( $P=0.51$ ). U usporedbi s prijemom, statistički značajno manje ispitanika je praznovjerno ( $P = 0.02$ ), a statistički manje ispitanika doživljava se kao bolesno (41% naspram 58.1%,  $P = 0.001$ ).

**Zaključak:** Duhovno-religijska podrška bolesnicima sa shizofrenijom pomaže kod duhovnih pitanja i religijskih dvojbi, doprinosi vjerovanju u Boga kao dobroćudnu višu silu i smanjuje vjerovanje u utjecaj negativne više sile kao uzroka bolesti i osobne nemoći. To je jedan od načina psihološke intervencije prema adekvatnijim misaonim procesima te doprinosi oporavku od bolesti.

**Ključne riječi:** shizofrenija, duhovnost, religioznost, praznovjerje