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Reflections from individuals with schizophrenia on a life with delusions and hallucinations: a phenomenological study

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Abstract

Background Despite their profound influence on the lives of individuals with schizophrenia, few studies explore delusions and hallucinations from the first-person perspective using a phenomenological approach. This study aimed to examine how individuals diagnosed with schizophrenia experience delusions and hallucinations from their own perspective.

Methods This descriptive phenomenological study was conducted between August and September 2023. Semi-structured, in-depth interviews were conducted with 14 individuals diagnosed with schizophrenia who regularly attended a state community mental health center in eastern Turkey. Interviews were audio-recorded, transcribed verbatim, and analyzed using Colaizzi's seven-step method. The study was reported in line with the COREQ checklist.

Results Four main themes were identified: (1) effects of schizophrenia, (2) triggers for delusions and hallucinations, (3) the impact of delusions and hallucinations on daily life, and (4) coping with delusions and hallucinations. Ten sub-themes captured psychological, physical, and social effects and triggers, as well as control mechanisms, challenges in life, perceived social support, and emotions.

Conclusion The findings highlight the pervasive psychological, physical, and social burden of living with delusions and hallucinations and the variability in coping resources and support. Developing and evaluating tailored psychosocial interventions may help individuals with schizophrenia manage these experiences more effectively. These findings suggest the need for developing psychoeducation programs focused on identifying personal symptom triggers, family-based support interventions that enhance communication and stigma reduction, and community mental health interventions aimed at strengthening coping skills, social participation, and emotional regulation.

Keywords Schizophrenia, Delusions, Hallucinations, Mental health, Phenomenological study

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Introduction

Schizophrenia is a severe mental disorder with a reported prevalence between 0.4% and 0.7% in society. It is characterized by a deterioration in thoughts, behaviors, and emotions, leading to an inability to distinguish between real and unreal situations [1]. Despite various definitions, there remains no universally agreed-upon definition for schizophrenia, and it is typically diagnosed using criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR) published by the American Psychiatric Association (APA) [1, 2]. Schizophrenia is a severe mental disorder that has been documented throughout history. In ancient times, when scientific research on schizophrenia was nonexistent, it was often attributed to supernatural causes, leading to societal fear and the isolation of affected individuals. Even today, societal misconceptions and beliefs continue to stigmatize those with schizophrenia, creating barriers to their treatment. Schizophrenia has profound negative effects not only on individuals but also on their caregivers, both emotionally and financially, due to the loss of their ability to perceive reality and other impairments [2, 3].

Despite numerous studies on schizophrenia, scientists have yet to fully elucidate its cause or causes. While it is generally accepted to be a brain-based disorder resulting from certain biological conditions, research indicates that various environmental and psychological factors, such as stress, sudden loss, and trauma, can also influence the onset or course of the disorder. Therefore, schizophrenia is believed to be a disorder influenced by biopsychosocial factors [2]. The diversity in the causes and processes of the disorder's occurrence has led to the use of various treatment approaches. Some studies suggest that the concurrent application of multiple methods, including drug therapy, electroconvulsive therapy (ECT), and psychotherapies, can positively impact treatment progress [4].

Positive symptoms of schizophrenia are easily identifiable and encompass "psychotic behaviors not seen in healthy individuals." These include hallucinations, hearing voices, and often paranoid delusions. Hallucinations and delusions, particularly paranoid ones, are the most challenging aspects of schizophrenia to comprehend. These symptoms often strain the patient's relationships because, while the patient perceives them as real, others view them as extraordinary and strange [5, 6].

Individuals diagnosed with schizophrenia may experience impaired reality evaluation, perception, thought, and interpretation disorders. They may also exhibit negative emotions and behaviors such as introversion, social isolation, distrust of family and the environment, ambivalent feelings, and fear of harm. These patients, when hospitalized, may resist treatment due to disturbances in their perception, thought processes, and the content of their thoughts. In some cases, they may even harbor delusions of persecution against the treatment team, believing that they will be harmed [2, 7]. Delusions and hallucinations are widely reported to have a substantial negative impact on individuals with schizophrenia, affecting emotional well-being, social relationships, daily functioning, and quality of life [1, 6]. Persistent psychotic symptoms are associated with social withdrawal, internalized stigma, impaired occupational functioning, sleep disturbances, and increased emotional distress [2, 6]. These symptoms often contribute to difficulties in maintaining interpersonal relationships and participating in community life, while also increasing the risk of depression, hopelessness, and reduced self-esteem. Collectively, findings from large-scale systematic review and qualitative synthesis indicate that delusions and hallucinations are among the strongest predictors of functional impairment and reduced quality of life in schizophrenia [2, 6, 8]. Despite their profound influence on the lives of individuals with schizophrenia, there are only a limited number of studies that deeply explore delusions and hallucinations from the perspective of those diagnosed with the disorder and examine them phenomenologically. Therefore, this study aims to assess how individuals diagnosed with schizophrenia experience delusions and hallucinations from their own perspective, using a phenomenological approach.

In addition to addressing a recognized gap in the literature, this study aims to provide an in depth, first person phenomenological account of living with delusions and hallucinations among individuals with schizophrenia in a non-Western cultural context. It further elucidates the psychological, physical, and social dimensions of symptom related burden together with perceived triggers and coping mechanisms, thereby offering an integrated framework that extends beyond symptom description. By foregrounding patients' own meanings and interpretations, the study generates practice oriented insights that may inform the development of culturally sensitive, recovery oriented psychosocial nursing interventions and community mental health programs.

Methods

Throughout the course of this study, the authors adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines, ensuring the comprehensive reporting of their research process [9]. (Annex 1).

Study design

This study adopted a descriptive phenomenological design. Data were analyzed using Colaizzi's seven-step descriptive phenomenological method, and reporting followed the COREQ checklist. This study was conducted between August 2023 and September 2023, using a

descriptive phenomenological approach. Semi-structured, in-depth individual interviews were conducted with 14 individuals with schizophrenia living in a province in eastern Turkey and regularly attending a state community mental health center for rehabilitation.

Research team and reflexivity

All three members of the research team are active faculty members working in the field of mental health, including two psychiatric nurses and one psychiatrist. Two of the researchers hold doctoral degrees in psychiatric nursing, and one is a medical doctor specialized in psychiatry. Two members of the team have prior experience working as clinical nurses in hospital settings. In addition, all three researchers received advanced training in qualitative research methods. Throughout the research process, the team members continuously considered the potential influence of their professional backgrounds, clinical experiences, and disciplinary expertise on data collection and analysis. To minimize possible biases, the researchers adopted a reflexive stance and maintained self-awareness during all stages of data collection and analysis.

Study group

The criterion sampling method, one of the purposeful sampling methods, was used to determine the study group for the research. Criterion sampling is the creation of a sample from people, events, objects, or situations that have the specified qualities related to the problem [10, 11]. The study was conducted through semi-structured, in-depth individual interviews with 14 individuals diagnosed with schizophrenia who live in a province in eastern Turkey and regularly visit a state community mental health center for rehabilitation. Interviews continued until data saturation was achieved, that is, until no new themes, categories, or meaningful information emerged from subsequent interviews. Accordingly, data saturation was achieved when 14 individuals were interviewed, and the interviews were terminated.

The inclusion criteria were (a) having a diagnosis of schizophrenia for at least 5 years, (b) having insight, (c) being open to communication, and (d) agreeing to participate in the study. Exclusion criteria were (a) having language, speech, or hearing impairments hindering communication, (b) refusing to participate in the study, and (c) not having delusions and hallucinations.

Data collection

A semi-structured interview form was developed based on a literature review, containing two parts. The first part covered demographic information such as age, gender, marital status, occupation, and socioeconomic status. The second part consisted of eight open-ended questions for use in the semi-structured interviews. The semi-structured interview form was developed following a focused review of qualitative studies on schizophrenia, delusions, hallucinations, stigma, and coping. Key thematic areas identified in previous research such as symptom-related distress, perceived triggers, social support, stigma experiences, and coping strategies were used to inform the development of the interview questions [1, 2, 6, 7, 11]. The form was reviewed by two experts in psychiatric nursing for content relevance and clarity before data collection. The questions in the semi-structured interview form were discussed with the individuals individually face-to-face [12]. During the interviews, individuals were encouraged to describe the effects of schizophrenia, share thoughts about delusions and hallucinations, and discuss triggering situations. The interviewers used probing questions such as “Can you elaborate on your answer?” and “What do you mean by this?” to facilitate deeper responses. All interviews were conducted by the second author. The interviews were recorded using a Sony voice recorder and transcribed verbatim by the same two researchers for analysis.

In the interviews, eight main questions were used to ask individuals diagnosed with schizophrenia about their lives with delusions and hallucinations from their perspective.

The questions in the semi-structured interview form were as follows:

1. Do you know your illness? What does schizophrenia mean to you?
2. Do you feel comfortable talking about your schizophrenia with the people around you? Can you explain the reasons?
3. What are the effects of schizophrenia on you? (What are the mental, physical, and social effects?) Do you think you cope effectively with schizophrenia? What are your sources of support in this process? Do you feel that you belong to this society?
4. What do you think about the delusions and hallucinations you experience?
5. In which situations do your delusions and hallucinations occur? Do they have any symptoms before they happen?
6. What triggers your delusions and hallucinations? Do you think you cope effectively with delusions and hallucinations?
7. How do delusions and hallucinations affect your life?
8. How do you cope with delusions and hallucinations?

Data analysis

In the analysis of the qualitative data obtained from the interviews, a 7-step analysis method developed by Colaizzi (1978) for phenomenological studies was utilized [13]. The interview texts were initially read

independently and repeatedly by three researchers to gain a thorough understanding of the data. This step aimed to comprehend the content and context of what was conveyed in the interviews. Significant statements within the interview texts were selected, reorganized, and expressed in more general terms to capture their essence. The researchers engaged in discussions and validations of the meanings they had formulated, identified, and organized the themes and sub-themes emerging from the data. The themes and sub-themes were articulated clearly. Throughout the analysis, participant statements were included to provide readers with the opportunity to validate the interpretation and analysis of the data to improve the credibility and transparency of the findings [14, 15].

Ethical considerations

This research was approved by the Hakkari University Scientific Research and Publication Ethics Committee (dated 01.08.2023, numbered 2023/83 – 01). Informed consent was obtained from the participants before starting the interview. Recordings and transcripts were stored on a password-protected device. The study was conducted in accordance with the Declaration of Helsinki and the ethical standards of the National Research Committee.

Results

The mean age of the participants was 36.85 ± 9.93. Of the 14 participants, eight were male and six were female. Twelve participants were single and two were married. In terms of educational level, eight participants were primary school graduates, five were high school graduates, and one participant was literate without formal schooling. Half of the participants were unemployed and half were self-employed. The majority reported that their income was less than their expenses, and most lived in the city center or district areas. The demographic characteristics of the individuals participating in the study are presented in Table 1.

The results presented below reflect participants' lived experiences of delusions and hallucinations and illustrate how these symptoms shape their psychological well-being, social relationships, and daily functioning. Themes, sub-themes and codes were determined from the analysis of the data obtained from semi-structured interviews (Table 2).

Theme 1. Effects of schizophrenia

Sub-theme 1. Psychological effects

Based on the data gathered from the interviews, participants reported a range of emotional and psychological challenges associated with their diagnosis of schizophrenia, like feelings of introversion, loneliness, irritability, a sense of inadequacy in dealing with delusions and hallucinations, increased suspicion, anxiety, fear, sadness, helplessness, and internalized stigma.

"I get anxious, I'm scared of the dark, and I hear voices. I even see a dog coming out of the wall. My brain was getting tired, and I couldn't sleep at night. I gained a lot of weight because of the medications. My knees hurt. I distanced myself from my friends because I didn't want to talk to anyone, and naturally, my friends started to drift away from me. My mom wanted to take me outside, but I didn't want to go out." (P7).

"I used to think about these things on my own and believed that they were real. When I told my sister, she said they were not real, and that made me feel sad. I thought I was an important person, studying at an important school and being someone significant." (P1).

Sub-theme 2. Social effects

The interviews with the participants revealed that the diagnosis of schizophrenia led to specific circumstances

Table 1 Sociodemographic characteristics

Participant number	Age	Gender	Marital status	Education level	Occupation	Income level	Place of residence
P1	45	Female	Single	Primary school	Unemployed	Income equal to expenses	City
P2	30	Female	Single	High school	Unemployed	Income less than expenses	District
P3	25	Male	Single	Primary school	Self-employed	Income less than expenses	District
P4	30	Female	Single	Primary school	Unemployed	Income equal to expenses	City
P5	25	Male	Single	Primary school	Self-employed	Income equal to expenses	City
P6	33	Male	Single	High school	Self-employed	Income less than expenses	City
P7	28	Female	Single	Primary school	Unemployed	Income less than expenses	District
P8	36	Male	Single	High school	Self-employed	Income more than expenses	District
P9	42	Male	Single	High school	Self-employed	Income less than expenses	City
P10	37	Male	Single	High school	Self-employed	Income less than expenses	City
P11	51	Female	Single	Literate	Unemployed	Income equal to expenses	City
P12	44	Female	Married	Primary school	Unemployed	Income less than expenses	City
P13	58	Male	Single	Primary school	Self-employed	Income less than expenses	District
P14	32	Male	Married	Primary school	Self-employed	Income less than expenses	District

Table 2 Summary of themes, sub-themes and open codes identified

Themes	Sub-themes	Codes
1. Effects of schizophrenia	**Psychological effects**	Introversion, Loneliness, Irritability, Feeling inadequate in managing delusions and hallucinations, Intensity of skeptical feelings, Anxiety, Fear, Sadness/unhappiness, Despair, Internalized stigma
	Social effects	Needing family support, The desire to get away from people, Not wanting to be intertwined with society
	Physical effects	Sleepiness, Weight gain due to medication, Decreased ability to speak, Not wanting to leave the house, Fatigue, Powerlessness, Headaches, Attempting suicide, Numbness in the body, Inability to work
2. Triggers for delusions and hallucinations	**Psychological triggers**	Fear, Loneliness, Angry, Stress, Sadness/unhappiness
	Physical triggers	Moving away from home, Discuss with family members, Irritability/anger, Fatigue, Insomnia, Praying, Performing ablution, Making Dhikr, Night/darkness, Spring season, Family quarrels
	Social triggers	Reduced social support, Crowd
3. The impact of delusions and hallucinations on lives	**Control mechanism**	Difficulty in controlling, Feeling like a prisoner, Focusing on delusions and hallucinations, Accepting delusions and hallucinations
	Challenges in life	Giving orders, Tracking, Saying repeated words, Insomnia, Suicidal thoughts, Thoughts of killing people, Difficulty in working, Detachment from the environment, Hating the family, Not wanting to see anyone
4. Coping with delusions and hallucinations	**Perception of social support**	Family support, Spousal support, Health personnel support, The desire to withdraw from society, Not discussing delusions and hallucinations with the family, Feeling isolated from the world, Taking refuge in God and praying
	Emotions	Hopelessness, Lack of sense of belonging, Decreased motivation, Mental distress, Internalized stigma

like an increased need for support from their families, a desire to distance themselves from social interactions, and a preference for avoiding societal involvement.

"My speaking ability has decreased, and I always feel sad. I'm taking medication for depression. I never want to leave the house, and when my family goes out, I don't want to go with them. When guests come to our house, I lock myself in my room." (P11).

"I hear voices. I usually hear the sounds of wolves, dogs, and monsters. I am very afraid of scorpions and snakes. I sleep next to my mother. I do not want to leave the house, and I do not want to be in crowded places." (P2).

Sub-theme 3. Physical effects

The interviews revealed that the participants faced physical difficulties such as loss of appetite, insomnia, fatigue, and weakness, all of which were attributed to their diagnosis of schizophrenia.

"I hear voices, and they threaten me, which makes me scared. I think they will harm me. I feel very weak and powerless. I can't even climb the stairs. I have a severe headache. I don't want to socialize with people much. I'm already unable to work. I'm facing financial difficulties, and I can't support my family." (P3).

"My body feels numb, I had no appetite, and I suffered from insomnia. I have headaches. I constantly feel weak and tired. There were voices speaking inside my head. I am unable to work." (P9).

Theme 2. Triggers for delusions and hallucinations

Sub-theme 1. Psychological triggers

The participants explained that their delusions and hallucinations were influenced by emotional states, including fear, loneliness, anger, stress, and sadness.

"The fights and shouting within the family trigger more delusions and hallucinations. I feel like I've been getting better since I started treatment. The people around me have noticed it too. They say I've improved, and hearing this makes me feel even better." (P6).

"My sister told me that I had gained a lot of weight and said that I would die if I did not lose weight. I took this very seriously, and when I dwell on such things, my hallucinations increase. I try to cope, but I cannot manage." (P10).

Sub-theme 2. Physical triggers

The participants mentioned that fatigue and insomnia could trigger their delusions and hallucinations.

"I used to experience delusions and hallucinations when I was tired, sleep-deprived, or feeling stressed. In fact, at the beginning, I used to hear them every day. I thought I was coping, but the truth is I couldn't because I still don't have a normal life." (P4).

"When I could not sleep at all, I experienced more voices, and when I became withdrawn and suffered from insomnia, I became very irritable beforehand." (P1).

Sub-theme 3. Social triggers

According to the interviews, reduced social support and crowded environments were potential triggers for delusions and hallucinations.

"I get uncomfortable in crowds. It gets worse in those moments. I want to be alone, and when I distance myself from the crowd, this feeling decreases." (P9).

"Sometimes they disturb me a lot, and during those times I struggle greatly. They make noise by hitting the walls in my home; when I am walking down the street, they curse at me and threaten me, and I curse back at them. At those moments, I hate them. However, I now try not to dwell on them too much and I am learning to accept their presence." (P3).

"I had suspicions. When someone passed by me, I felt as if they were going to pull out a knife and kill me. I could hear what people were thinking about me, as if I could hear their inner voices. I could not get out of bed, and there was a constant heaviness over me. After I became ill, there were not many people left around me, and I no longer want to do anything. I do not want to be in crowded places." (P5).

Theme 3. The impact of delusions and hallucinations on lives

Sub-theme 1. Control mechanism

The interviews highlighted the profound impact of delusions and hallucinations on the individuals' lives, demonstrating that these experiences disrupted their coping mechanisms and well-being.

"I struggle when they interfere with my work; they keep telling me things all the time and giving me orders. I don't want to listen to them, but they won't leave me alone." (P4).

"I do not think they are real. I am aware that they are related to my illness. However, sometimes I have certain dreams. In one of my dreams, I saw the Prophet. When I read the Holy Qur'an, I see scholars among the letters. These experiences make me feel pleased and happy." (P3).

"The voices I heard kept repeating the same words. It felt like an obsession. I found myself repeating what I heard. This exhausted me greatly. I felt like a prisoner, and I could not cope with them." (P5).

Sub-theme 2. Challenges in life

Interviews revealed that individuals experienced some difficulties in their lives due to delusions and hallucinations.

"It's affecting my life badly. I have disturbing thoughts. Thoughts of death come to mind- thoughts of killing people. Then God comes to mind, and I reconsider. I don't want to upset God." (P8).

"Sometimes they really bother me, and that's when I struggle a lot. They make noise by hitting the wall at home; they curse at me when I'm walking down the street; they threaten me; and I curse back at them. Then, I started to hate them. But now, I try not to let them bother me too much. I'm learning to accept their presence." (P2).

Theme 4. Coping with delusions and hallucinations

Sub-theme 1. Perception of social support

In the interviews, while some participants reported receiving essential social support from their families and especially their spouses, others expressed a desire to distance themselves from society due to a perceived lack of support.

"I'm trying to cope with it. My spouse is supportive, and we try not to make it obvious to the children. Of course, I do feel like I belong to society, but when my delusions and hallucinations increase, I sometimes think differently. I've started to believe that I'm someone special. At that point, I see myself as someone different from the rest of society." (P2).

"I believe this illness will reach a point where it won't bother me anymore because there's a big difference between how I was four years ago and how I am now. I receive support from my father and healthcare professionals. But sometimes, I get thoughts as if I don't belong in this world." (P5).

Sub-theme 2. Emotions

The interviews indicated that individuals diagnosed with schizophrenia grappled with feelings of hopelessness, an inability to establish a sense of belonging, diminished motivation, future-related anxieties, and the internalization of societal stigmas associated with their condition.

My family and my doctor support me. Sometimes, I don't feel like I belong to society. I think I'm different and special. I try to explain to people that I'm ill. But in the community I live in, they've labeled me as crazy. When I go out, children make fun of me, and it really upsets me. (P8).

"I cannot talk to anyone. They think I am crazy, and I feel ashamed." (P11).

"I hear children's voices. They are the children of my illness. There is also someone inside me that I sometimes talk to. I also see two eyes. But I know these are related to my illness and are not real. Because of this, I do not feel that I belong to this society." (P12).

Discussion

This study aimed to explore how individuals diagnosed with schizophrenia experience delusions and hallucinations from their own perspective. The Discussion below interprets the main findings and situates them within the context of existing qualitative and quantitative research.

Effects of schizophrenia

The findings of this study show that schizophrenia affects individuals not only through its clinical symptoms, but also through profound psychological, social, and physical consequences that shape their everyday lives. Participants described feelings of loneliness, fear, sadness, hopelessness, and internalized stigma, as well as social withdrawal and physical exhaustion, revealing that the burden of the illness extends far beyond symptom presence. These experiences are consistent with previous studies indicating that schizophrenia significantly impairs psychosocial functioning and quality of life, while also leading to social isolation, reduced self-esteem, and diminished hope [16–18]. However, our findings add a more personal and experiential dimension to this knowledge by illustrating

how these difficulties are perceived, interpreted, and lived by individuals themselves. In particular, participants' narratives highlight how emotional distress, physical fatigue, and social withdrawal are deeply intertwined, creating a cycle that further complicates coping with delusions and hallucinations.

Individuals diagnosed with schizophrenia often face exclusion and isolation from society due to their distinctive behavior, which sets them apart from others. Their timidity is driven by a fear of failure; they experience loneliness stemming from difficulties in decision-making; and they tend to fixate on their weaknesses. The cognitive impairments inherent in schizophrenia not only lead to forgetfulness, inattention, and a lack of motivation but also hinder their acceptance within their social environment. Consequently, these individuals often remain dependent on their families, with a significant portion of them living with their immediate relatives. In fact, it has been reported that 67% of patients with schizophrenia have never been married [19]. These findings align with the existing literature, highlighting schizophrenia as a chronic mental illness that profoundly impacts individuals' entire lives.

Triggers for delusions and hallucinations

Participants in this study described a wide range of emotional, physical, and social situations that appeared to intensify their delusions and hallucinations. Feelings such as fear, loneliness, anger, sadness, and stress were frequently mentioned as psychological triggers, while fatigue and sleep problems were commonly reported physical precursors. Socially, crowded environments and reduced social support were perceived as situations in which symptoms became more difficult to manage. These narratives suggest that delusions and hallucinations are not experienced as static or isolated phenomena, but rather as symptoms that fluctuate in close interaction with daily life stressors and environmental conditions [20, 21].

These findings are largely consistent with existing literature indicating that sleep disturbance, stress, and emotional dysregulation play an important role in the exacerbation of psychotic symptoms [8, 22]. However, our participants' accounts add nuance by showing how individuals themselves recognize and interpret these triggers in their everyday lives. For many, identifying personal warning signs such as increased tension, fatigue, or discomfort in social settings was an important step toward understanding their symptoms and attempting to regain a sense of control.

To investigate this, they conducted an experiment with thirty patients experiencing persecution delusions. These individuals were immersed in a virtual reality subway scenario and were instructed to either focus on the cognitive antecedents (predefined) of their auditory hallucinations or engage in neutral cognitive activities unrelated to their hallucinations. However, the results showed that both groups experienced auditory hallucinations to the same extent in the virtual reality setting, failing to provide evidence that cognitive antecedents trigger auditory hallucinations [22]. Interestingly, participants in the study commonly reported that delusions and hallucinations became more pronounced in situations involving sleep deprivation, tiredness, darkness, and nighttime.

The impact of delusions and hallucinations on lives

The findings indicate that delusions and hallucinations have a pervasive and deeply disruptive influence on individuals' daily functioning. Participants described these experiences as intrusive, persistent, and difficult to control, often interfering with their ability to work, maintain relationships, and carry out routine activities. Voices giving orders, feelings of being monitored, and repetitive intrusive thoughts were commonly reported, illustrating how psychotic symptoms can dominate attention and reduce individuals' sense of autonomy. Many participants also expressed fear, distress, and even aggressive or suicidal thoughts, underscoring the emotional burden associated with living under the constant pressure of these experiences.

These findings are in line with previous research showing that auditory hallucinations and persecutory delusions are associated with impaired functioning, heightened emotional distress, and reduced quality of life [23–25]. However, our participants' narratives provide a more experiential understanding of how these symptoms are lived on a daily basis. Rather than being perceived merely as clinical phenomena, delusions and hallucinations were described as forces that "take over" one's life, shape daily decisions, and limit personal freedom, highlighting the need for interventions that address both symptom management and everyday functioning.

Coping with delusions and hallucinations

Participants described coping with delusions and hallucinations as an ongoing and highly personal process. Many relied primarily on family members, spouses, and healthcare professionals for emotional and practical support, while others preferred to withdraw from social environments to protect themselves from stigma and emotional overload. Some participants also reported turning to religious practices such as prayer as a source of comfort and meaning. These coping patterns suggest that individuals actively seek ways to manage their experiences, even when their resources and support systems are limited.

Social support and religious coping mechanisms hold significant importance in dealing with delusions and hallucinations, which are cardinal symptoms of

schizophrenia. Pietkiewicz et al., (2021) emphasized the role of religion in helping individuals cope with delusions and hallucinations [24]. Suwa and Yumoto (2019) reported that patients often refrain from sharing their delusions and hallucinations with their families to cope with visual hallucinations, resulting in mental distress [26]. Our study underscored the importance of family support in managing delusions and hallucinations, while also acknowledging that some individuals may choose not to disclose these experiences to their families.

Consistent with previous research emphasizing the importance of family involvement and social support in schizophrenia care [20, 26], our findings highlight that supportive relationships can play a crucial role in helping individuals endure and make sense of their symptoms. At the same time, participants' reluctance to share their experiences with others reflects the continuing impact of stigma and fear of social judgment. Together, these findings point to the need for community-based, culturally sensitive psychosocial interventions that not only address symptom management but also strengthen social support, reduce stigma, and promote recovery oriented care.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, all participants were recruited from a single community mental health center in a province in eastern Turkey, which may limit the transferability of the results to other regions or service settings. Second, the relatively small sample size inherent to qualitative phenomenological research may not capture the full diversity of experiences among individuals living with schizophrenia. Finally, data were based on self-reported narratives, which may be influenced by recall bias and individual differences in insight and symptom awareness. Despite these limitations, the study provides rich, in-depth insights into the lived experiences of delusions and hallucinations.

Conclusion

In conclusion, this study demonstrates that living with schizophrenia, particularly with delusions and hallucinations, involves complex psychological, physical, and social challenges that shape individuals' everyday lives. Participants' narratives reveal that these experiences are not limited to symptom severity alone but are closely intertwined with feelings of stigma, social withdrawal, emotional distress, and varying levels of social support. Individuals employ diverse coping strategies, often relying on family, healthcare professionals, and personal meaning-making practices. These findings underscore the importance of developing recovery-oriented, culturally sensitive psychosocial nursing interventions that address both symptom management and everyday functioning, and that strengthen social support and community integration.

Table 3 Combined criteria for reporting qualitative research (COREQ)

Number	Characteristics	Guiding questions	Explanations
Domain 1: Research team and reflexivity			
Personal Characteristics			
1	Interviewer/facilitator	Which author(s) conducted the interview or focus group?	The second author conducted the interview
2	Credentials	What were the credentials of the researchers? e.g., Ph.D., MD	First author: Ph.D. Second author: Ph.D. Third author: Psychiatrist
3	Occupation	What was their occupation during the study?	First author: Ph.D. Faculty Member, Psychiatric Nursing Second author: Ph.D. Faculty Member, Psychiatric Nursing Third author: Psychiatrist
4	Gender	What was the sex of the researcher?	Two researchers: Female One researchers: Male
5	Experience and education	What are the experiences and education levels of the researchers?	The first author has taken qualitative courses and published qualitative studies in international journals. The second author has taken qualitative courses. The third author has taken qualitative courses
Relationships with participants			
6	Relationship status	Was there a relationship between the researcher and the participants before the training?	No, there was not
7	Interviewee's information about the interviewer	What did the participants know about the researcher, e.g., personal goals and reasons for doing the research?	Participants knew that the researcher had a doctorate in the field of mental health and diseases
8	Interviewee characteristics	What characteristics of the interviewer or facilitator were reported? e.g., bias, assumptions, reasons, and interests in research	At the beginning of each interview, the nurses were informed about the aim and objectives of the study
Domain 2: Study Design			
Theoretical framework			
9	Methodological orientation and theory	What methodological orientation was identified to support the study, e.g., discourse analysis, ethnography, phenomenology, and content analysis?	It was a qualitative study
Sampling			
10	Sampling	How were the participants selected? e.g., purposeful, convenience, consecutive, snowball	The criterion sampling method, one of the purposive sampling methods, was used
11	Approach method	How were the participants reached? e.g., face-to-face, telephone, mail	The timing of the interviews was determined by the participants who agreed to take part in the study
12	Sample size	How many participants were there in the study?	A total of 14 participants were included in the study
13	Exclusion	How many people refused to participate or dropped out? Reasons?	No participants refused to participate in the study
Setting			
14	The setting of data collection	Where were the data collected? e.g., home, clinic, or workplace	Detailed information is given in the data collection section of the study
15	Presence of non-participants	Was there anyone else other than the participants and the researchers?	No, there was not
16	Description of the sample	What are the important characteristics of the sample? e.g., demographic data, date	Individuals diagnosed with schizophrenia who met the inclusion criteria and regularly attended the community mental health center were included
Data collection			
17	Interview guide	Were questions, prompts, and guidelines provided by the authors? Were they tested in a pilot study?	Detailed information is given in the methods section
18	Repeat interviews	Were repeated interviews conducted? If yes, how many?	No, they were not
19	Audio/visual recording	Was audio recording or visual recording used to collect data in the research?	Interviews were recorded with a voice recorder

Table 3 (continued)

Number	Characteristics	Guiding questions	Explanations
20	Field notes	Were field notes taken during and/or after the interview or focus group?	All responses and researcher observations were recorded
21	Duration	How long were the interviews or focus groups?	Each interview lasted between 35 and 45 min
22	Data saturation	Was data saturation discussed?	Yes, it was
23	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No, they were not
Domain 3: Analysis and results			
24	Number of data coders	How many data coders coded the data?	Two researchers and a third individual coded the data
25	Description of the coding tree	Did the authors describe the coding tree?	The titles and subtitles in the results section represent the final coding tree
26	Derivation of themes	Were the themes predetermined or derived from the data?	Themes were derived from the data
27	Software	If any, what software was used to manage the data?	The data were analyzed manually
28	Participant control	Did participants provide feedback on the findings?	No, they did not
Reporting			
29	Quotations provided	Are participant quotes cited to illustrate themes/findings? Is each quote identified, e.g., by participant number?	Yes, they are. Participant quotes are provided to illustrate themes/findings. e.g., participant number
30	Data and findings consistent	Was there consistency between the data presented and the findings?	Yes, there was
31	Clarity of main themes	Are the main themes clearly presented in the findings?	Yes, they are
32	Clarity of subthemes	Is there a description of the different cases or a discussion of minor issues?	Yes, there is

Annex 1

See Table 3.

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Author contributions
S.U., Ç.E., and M.B.E.: Writing – review & editing, Writing – original draft, Validation, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. S.U., Ç.E., and M.B.E.: Writing – original draft, Methodology, Data curation, Conceptualization.

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Data availability
All data generated or analysed during this study are included in this published article and its supplementary information files.

Declarations

Ethics approval and consent to participate
This research was approved by the Hakkari University Scientific Research and Publication Ethics Committee (dated 01.08.2023, numbered 2023/83 – 01). Participants provided informed consent before participating in interviews, aligning with the principles of the Declaration of Helsinki and the ethical standards of the National Research Committee. Written informed consent was also obtained from each participant before recruitment into the study. Each participant was informed of his/her right to withdraw from the study at any time without sufering any negative consequences. Names of the participants were not revealed in the study report and all information gathered from the study participants were treated confdentially as special codes were used to represent the responses of each participant.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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