

DELUSIONAL DISORDER

DSM-IV

297.1 Delusional disorder

SPECIFIC TYPE:

Erotomaniac (delusions that another person of higher status is in love with the individual)

Grandiose (delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person)

Jealous (delusions that one's sexual partner is unfaithful)

Persecutory (delusions that one, or someone to whom one is close, is being malevolently treated in some way)

Somatic (delusions that one has some physical defect or general medical condition)

Mixed (delusions characteristic of more than one of the above types, but no one theme predominates)

ETIOLOGICAL THEORIES

Psychodynamics

Emotional development is delayed because of a lack of maternal stimulation/attention. The infant is deprived of a sense of security and fails to establish basic trust. A fragile ego results in severely impaired self-esteem, a sense of loss of control, fear, and severe anxiety. A suspicious attitude toward others is manifested and may continue throughout life. Projection is the most common mechanism used as a defense against feelings.

Biological

A relatively strong familial pattern of involvement appears to be associated with these disorders. Individuals whose family members manifest symptoms of these disorders are at greater risk for development than the general population. Twin studies have also suggested genetic involvement.

Family Dynamics

Some theorists believe that paranoid persons had parents who were distant, rigid, demanding, and perfectionistic, engendering rage, a sense of exaggerated self-importance, and mistrust in the individual. The clients become vulnerable as adults because of this early experience.

CLIENT ASSESSMENT DATA BASE

Refer to CP: Schizophrenia for physical symptoms.

Ego Integrity

May present with severe anxiety; inability to relax, exaggeration of difficulties, being easily agitated

Expresses feelings of inadequacy, worthlessness, lack of acceptance, and trust of others

Demonstrates difficulty in coping with stress, uses maladjusted coping mechanisms (e.g., excessive use of projection and aggressive behavior, takes unnecessary precautions, avoids accepting blame)

Neurosensory

Nonbizarre delusional system of at least 1 month's duration

Experiencing emotions and behavior congruent with the content of belief system/fears that either self or significant others are in danger, are being followed/conspired against, poisoned, infected; have a disease; are being deceived by one's spouse, cheated by others; are loving/being loved from a distance.

Exhibits controlled, cold, unemotional affect; guarded/evasive/distrustful behavior

Vigilant, looks for hidden motives; every person/event is under suspicion

Displays keen perception; will demonstrate impaired judgment about the perception

Delusions of reference or control that may incorporate the FBI, CIA, radio/TV

(Prominent auditory or visual hallucinations not usually present)

Safety

May display assaultive/violent behavior

Social Interactions

Significant impairment in social/marital functioning possibly noted; behavior in all other areas of life usually normal

Litigiousness common

Teaching/Learning

Onset most often in middle or late adult life

May have history of substance abuse/physical illness

DIAGNOSTIC STUDIES

Refer to CP: Schizophrenia.

NURSING PRIORITIES

1. Promote safe environment, safety of client/others.
2. Provide open, honest atmosphere in which client can begin to trust self/others.
3. Encourage client/family to focus on defining methods for coping with anxieties and life stressors.
4. Promote a sense of self-worth and increased self-esteem.

DISCHARGE GOALS

1. Copes with anxiety without the use of threats or assaultive behavior.
2. Recognizes reality; agrees to give up or live with the delusional system.
3. Client/family/SOs participate in therapy (e.g., behavioral, group).
4. Family/SO(s) provide emotional support for the client.
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS**Risk Factors May Include:****[Possible Indicators:]****Desired Outcomes/Evaluation Criteria—****Client Will:****VIOLENCE, risk for, directed at self/others**

Perceived threats of danger

Increased feelings of anxiety

Acting out in an irrational manner

Becoming threatening or assaultive in the face of perceived threat

Verbalize awareness of delusional system.

Resolve conflicts, coping with anxiety without the use of threats or assaultive behavior.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Note prior history of violent behavior when under stress.

Assist client to identify situations that trigger anxiety and aggressive behaviors.

Explore implications and consequences of handling these situations with aggression.

Encourage to engage in solitary activity instead of group activities to being with.

Be careful in offering a pat on the shoulder/hug, etc.

Assist client to define alternatives to aggressive behaviors. Engage in physical activities such as Ping-Pong, foosball. (Monitor competitive activities; use with caution.)

Encourage verbalizations of feelings and promote outlet for expression.

Monitor level of anger (i.e., questioning, refusal, verbal release, intimidation, blow-up).

Be alert to signs of impending violent behavior (e.g., increase in psychomotor activity, intensity of affect, verbalization of delusional thinking, especially threatening expressions).

Indicator of increased risk for recurrence of aggression/violent behavior.

Understanding relationship between severe anxiety and aggressive feelings can help client identify options to avoid violent behavior.

Emphasizes importance of thinking through situations before acting.

Anxiety, fear, and suspiciousness may escalate if client is involved in competitive/group activities.

Gestures involving touch may be misinterpreted as aggressive by the suspicious person.

Enables client to learn to handle situations in a socially acceptable manner. Appropriate outlets will allow for release of hostility. **Note:** Competition can trigger violent behavior.

Ventilation of feelings reduces need for physical action.

Helps determine seriousness of therapeutic need and affects choice of interventions.

Therapeutic interventions are more effective before behavior becomes violent.

Accept verbal hostility without retaliation or defense. Nurse (caregiver) needs to be aware of own response to client behavior (e.g., anger/fear).

Institute de-escalation actions as indicated, e.g.:

Distance self from client, at least 4 arm lengths, position self to one side; remain calm, stand or sit still, assume “open” posture with hands in sight;

Speak softly, call client by name, acknowledge client’s feelings, express regret about situation, show empathy;

Avoid pointing, touching, ordering, scolding, challenging, interrupting, arguing with, belittling, or intimidating client;

Request permission to ask questions; try to discern triggering event and any underlying emotions, such as fear, anxiety, or humiliation; offering solutions/alternatives.

Provide safe, quiet environment; tell client she or he is “safe.”

Isolate promptly in nonpunitive manner, using adequate help if violent behavior occurs. Hold client if necessary. Tell client to STOP behavior.

Collaborative

Administer medications, as indicated. (Refer to ND: Anxiety, severe.)

Behavior is not usually directed at nurse personally, and responding defensively may exacerbate situation. Concentrating on meaning behind the words is more productive. Awareness of own response allows nurse to confront/deal with those feelings.

Can prevent escalation of violent behaviors and potential injury to client/caregivers or bystanders. Reduces the possibility that client will feel confronted or blocked.

Communicates sense of respect, belief that individual can be trusted to control self, and that caregiver is available to assist client with resolution of situation. **Note:** Even though you are projecting an attitude of trust, it is important to expect the unexpected and be prepared. These actions may be viewed as threatening and may provoke client to violence.

Involves client in problem-solving and gives client some control over situation.

Keeping environmental stimuli to a minimum will help reassure client and assist with prevention of agitation.

Removal to a quiet environment can help calm client. Sufficient help will prevent injury to client/staff. Usually the individual is being self-critical and afraid of hostility and does not need external criticisms. Saying “Stop” may be enough to allow client to regain control.

Antipsychotic/antianxiety drugs may decrease anxiety and delusional thinking, decreasing suspicious thoughts/aggressive behaviors and aiding client in maintaining control.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

ANXIETY [severe]

Inability to trust (has not mastered tasks of trust vs. mistrust)

Rigid delusional system (provides relief from stress that justifies the delusion)

Frightened of other people and own hostility

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Acknowledge delusion and deal with it appropriately.
Define methods to decrease own anxiety level.
Report anxiety is reduced to a manageable level.
Demonstrate a relaxed manner.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Develop primary nurse/client relationship.

The continuity of a primary care relationship can provide the time necessary to form an alliance with the suspicious person.

Assist client to identify sources of anxiety and concerns.

Increases awareness of problems/contributing factors. Client needs to become aware of how behavior affects others and take responsibility for it.

Explore present patterns of coping with anxiety and how effective they have been (e.g., threatening harm and/or shouting at others, believing “they are out to get me/my family”).

Increases awareness that aggressive acts may have destructive outcome.

Discuss alternatives to current ineffective behaviors.

Client has been using maladjusted coping; identifying effective, constructive strategies to handle fearful situations can be an impetus to change.

Encourage implementation of new strategies, giving feedback on effectiveness.

Reinforces acceptable behaviors.

Avoid confrontation of delusion.

Logic does not work, and forcing the client to give up the delusion increases anxiety.

Observe for side effects of medications: note changes in behavior/response to environment, level of consciousness, intellectual responses/thought control; reports of dry mouth, blurred vision. Monitor vital signs, intake/output, weight.

Adverse reactions such as extrapyramidal symptoms, tardive dyskinesia, orthostatic hypotension, decreased sensation of thirst, constipation, urinary retention, weight gain may occur; paradoxical exacerbations of psychotic symptoms may develop and may actually heighten anxiety, suspiciousness

Collaborative

Develop behavioral therapy program with input and agreement of client, family/SO, and therapeutic team.

Hypersensitivity to the actions of others has been learned and can be unlearned. Breaking this cycle assists in reducing sensitivity to criticism and improving client’s social skills.

Administer medications as indicated, e.g., fluphenazine (Prolixin), haloperidol (Haldol).

Decreases anxiety and delusional thinking, which can increase ability to problem-solve. **Note:** Decreased sensation of thirst and sensitivity to sun/photophobia are side effects of antipsychotic drugs that require increased fluid intake and avoidance of prolonged exposure to sun.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—
Client Will:**

POWERLESSNESS

Lifestyle of helplessness: Feelings of inadequacies, sense of severely impaired self-esteem

Interpersonal interaction

Verbal expressions of having no control/influence over situation(s)

Use of paranoid delusions, aggressive behavior to compensate for lack of control

Expressions of recognition of damage paranoia has caused self and others

State belief that outcome of situations causing concern can be significantly affected by own actions.

Identify individual actions to effect control.

Demonstrate necessary behaviors/lifestyle changes to maintain control without use of aggression.

ACTIONS/INTERVENTIONS**Independent**

Encourage client to do as much for self as able, providing choices when possible.

Assist client to identify when feelings of loss of control began and events/situations that led to feelings of powerlessness and aggressive acts.

Review previous relationships/social contacts. If client is no longer involved in these relationships, have her or him describe what happened.

Discuss pre-delusional period and how events might precede panic state.

RATIONALE

Permits/enables control of situation so suspicion can be reduced.

Increases understanding of sources of stressful events and that aggression is an attempt to compensate for feeling powerless.

Knowledge can be gained of how the client establishes relationships and why they deteriorated or remained intact, providing insight to change own behavior and enhancing future relationships.

Helps client discern how much of delusion is real and how much relates to anxiety state.

Explore alternate ways to regain control without resorting to aggression. (Refer to ND: Violence, risk for.)

Give positive feedback when client demonstrates use of constructive alternatives.

Provides knowledge of constructive coping mechanisms.

Enhances self-esteem and reinforces acceptable behaviors.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—
Client Will:**

THOUGHT PROCESSES, altered

Psychological conflicts

Increasing anxiety and fear (characteristic of the suspicious person)

Interference with the ability to think clearly and logically, difficulties in the process and character of thought, fragmentation and autistic thinking, delusions

Beliefs and behaviors of suspicion/violence

Recognize changes in thinking/behavior, and relationship of paranoid ideation to current situation.

Identify the meaning of the delusion.

Deal with anxieties/fears as evidenced by more logical/reality-based thinking.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

State reality matter-of-factly. Communicate in clear, concise terms with clearly stated rules what client can/cannot do.

Provide outlet(s) for expression of thoughts in 1:1 or group settings.

Have a client keep a log of anxious feelings and accompanying thoughts. Review with client.

Help client identify/discuss thoughts, perceptions, and own conclusions of reality.

The very suspicious/delusional client needs to have straight information that differentiates him or her from the seemingly dangerous surroundings. Knowledge of the rules can provide this person with a sense of control.

In a trusting relationship, feelings can be freely expressed without fear of judgment.

Guided writing exercises can be used, with caution, to help client identify precipitating events and provide an opportunity to identify reality and change behavior. **Note:** Narrative writing is not recommended, as it may actually reinforce delusional system.

Increases comprehension of what client sees as problems and gives insight into how information is being processed.

Note impulsive behaviors and request client to stop. If client does not stop, evaluate basis of behavior and whether it is potentially harmful. (Refer to ND: Violence, risk for.)

Encourage client to identify when fears/suspicious began and events that led to these feelings.

Explore how perceptions are validated before drawing conclusions. Discuss successes and failures of these attempts.

Guide client in defining methods to deal with misperceptions without distortion of reality or using delusional system.

Encourage development of exercise programs. Instruct in use of appropriate relaxation techniques (e.g., breathing exercises, progressive relaxation activity).

Gradually involve client in learning activities, occupational/recreational/activity therapies. (Refer to ND: Self Esteem disturbance.)

These behaviors are often the result of psychotic thought/perceptual distortions and not willful actions.

Gaining knowledge of stressors that have precipitated deterioration in coping ability may help prevent recurrence of these behaviors.

Validation of perceptions may prevent drawing the wrong conclusion and acting-out behaviors.

Decreasing fears/anxieties and the client's repertoire of coping behaviors may prevent decompensation. (Refer to ND: Anxiety [severe].)

Can alleviate tension, promoting sense of well-being. **Note:** Use of guided imagery may exacerbate delusional thinking.

As thought processes improve, task mastery opportunities can enhance self-esteem and enable the client to feel good about accomplishments.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—
Client Will:**

SELF ESTEEM disturbance

Underdeveloped ego, fixation in earlier level of development, inability to trust

Lack of positive feedback

Delusional system (attempt to hurt or strike out at someone else to protect the self); self-destructive behavior

Inability to accept positive reinforcement

Not taking responsibility for self-care; nonparticipation in therapy

Verbalize feelings of increased self-value/worth.

Identify self as a person capable of problem-solving and functioning in society in a manner acceptable to self and others.

Demonstrate adaptation to changes by active participation in treatment program.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Provide clear, consistent verbal/nonverbal communication. Be truthful and honest; follow through on commitments.

Encourage client to verbalize feelings of inadequacies, worthlessness, fear of rejection/need for acceptance by others.

Explore how these negative feelings could lead to severe anxiety and suspiciousness.

Encourage client to identify positive aspects about self related to social skills, work abilities, education, talents, and appearance.

Give positive feedback regarding abilities and how they can be used to increase self-esteem.

Engage in activities, increasing socialization and interaction with others as tolerated.

Helpful in establishing trust and reaffirms that the individual has value and worth.

Must have insight into own feelings to begin to improve self-esteem.

Increases awareness of internal factors that cause feelings of inadequacy and how these feelings lead to decompensation.

Reinforces own feelings of being a worthwhile person capable of adaptive functioning.

Provides encouragement and promotes a sense of self-direction.

Opportunity to interact with others reduces isolation, enhances feelings of self-worth, and promotes social skills.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

**Desired Outcomes/Evaluation Criteria—
Client Will:**

SOCIAL INTERACTION, impaired

Disturbed thought processes, mistrust of others/delusional thinking

Knowledge/skill deficit about ways to enhance mutuality

Discomfort in social situations, difficulty in establishing relationships with others

Expressions of feelings of rejection, no sense of belonging; isolation of self/withdrawal

Dealing with problems with anger/hostility and violence

Verbalize willingness to be involved with others.

Participate in activities/programs with others with lessened discomfort.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Establish 1:1 relationship, use Active-listening, and provide safe environment for self-disclosure.

Determine degree of impairment, listening to client's comments about loneliness. Note sense of self-esteem. (Refer to ND: Self Esteem disturbance.)

Encourage client to verbalize feelings of discomfort about social situations and perceptions of reasons for problems.

Observe and describe social/interpersonal behaviors in objective terms.

Identify support systems available to the client: family, friends, coworkers, etc.

Assess family relationships, communication patterns, knowledge of client condition.

Explore and role-play means of changing social interactions/behaviors. Provide positive feedback for efforts.

Consistent, brief, honest contact can help the client initiate and master tasks associated with learning to trust others.

Mistrust can lead to difficulty establishing relationships, and client may have withdrawn from close contacts with others.

Acknowledgement helps client to become aware of feelings and begin to deal with them.

Provides insight into how others view them and may serve as a beginning for change.

Can be an important part in the client's rehabilitation by improving socialization and diminishing sense of isolation.

Problems within the family can preclude members providing adequate support/continuing relationship and may interfere with client's progress. (Refer to ND: Family Coping, ineffective: compromised/Family Processes, altered.)

Provides safe environment to try out new behaviors. Encouragement enhances repetition and risk-taking.

NURSING DIAGNOSIS

FAMILY COPING, ineffective: compromised/FAMILY PROCESSES, altered

May Be Related to:

Temporary family disorganization/role changes

Inadequate or incorrect information or understanding by a primary person

Prolonged progression of condition that exhausts the supportive capacity of significant other(s)

Possibly Evidenced by:

Family system does not meet physical/emotional/spiritual needs of its members

Inability to express/accept wide range of feelings within self and other family members

Inappropriate or poorly communicated family rules, rituals, symbols

Inappropriate boundary maintenance

**Desired Outcomes/Evaluation Criteria—
Family Will:**

Significant person describes preoccupation with personal reactions, withdraws or enters into limited or temporary personal communication with client at time of need

Identify/verbalize resources within itself to deal with the situation.

Interact appropriately with the client.

Provide opportunity for client to deal with situation in own way.

Identify need for outside support and use appropriately.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Identify individual factors that may contribute to difficulty of family in providing needed assistance to the client.

Each member of a family system has an effect on other members, and members of this family may be in constant conflict with each other.

Determine information available to and understood by family/significant other(s).

Lack of understanding of illness can lead to angry responses in family members, resulting in continuing conflict.

Discuss underlying reasons for client's behaviors (e.g., fear of loss of control, extreme sensitivity, use of projection and blame to avoid looking at own responsibility).

Promotes understanding of client and provides opportunity for changing ineffective responses to positive, growth-promoting behaviors.

Encourage and assist client/family to develop problem-solving skills.

This client's behavior creates conflict among family members, and learning to resolve issues in an open, nonjudgmental manner lessens angry responses, allowing for resolution of the conflict.

Help individuals to look at own behavior in relation to the client's.

Interaction among family members often enables the client to maintain suspicions and paranoid ideation, and when this behavior is acknowledged and dealt with, behavior can begin to change.

Collaborative

Refer to appropriate resources such as marital/family therapy, psychotherapy, support groups.

Since conflict is so prevalent in this family, and divorce is common, long-term assistance may be needed to maintain relationships or achieve amicable parting.