Delusional Disorder: Grandiose Type

Description/Etiology

Delusional disorder is characterized by the presence for at least one month of delusions and the absence of other symptoms associated with psychotic, mood, or personality disorders that usually include delusions. Delusions are fixed beliefs that persist despite objective evidence that they are not true. Whether a particular belief is considered delusional varies from culture to culture; to be considered a delusion the belief cannot be accepted by members of the believer’s own culture or subculture. Delusions are categorized as either nonbizarre or bizarre. Nonbizarre delusions are beliefs that could conceivably be true (e.g., a life partner having an affair, being the object of unspoken love, being spied on by a government agency), whereas bizarre delusions have no possible basis in reality (e.g., having all of one’s organs replaced without surgery, being controlled by messages received from the CIA through a hat made of aluminum foil).

The primary change in criteria for diagnosis of delusional disorder in the Diagnostic and Statistical Manual of Mental Health Disorders, fifth edition (DSM-5) from the fourth edition of the manual is the removal of the requirement that delusions are nonbizarre. The criteria for delusional disorder are delusions of at least one month’s duration; criterion A for schizophrenia has never been met (nonprominent hallucinations that are related to the theme of the delusion may be present); functioning is not noticeably impaired and behavior is not odd (except possibly for the direct impact and ramifications of the delusion); symptoms of mood disorders, if any, are brief relative to the duration of the delusion; and the delusion is not directly due to a general medical condition or the physiological effect of a substance. DSM-5 added specifiers concerning bizarre content, course, and severity of symptoms (American Psychiatric Association, 2013).

There are numerous possible medical causes of delusions, including neurodegenerative disorders, central nervous system disorders, vascular diseases, infectious diseases, metabolic diseases, endocrine disorders (e.g., hyperthyroidism, hypothyroidism), vitamin deficiencies, medications, toxins, and psychoactive substances. The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) criteria for delusional disorder are essentially the same as those of the DSM-5 except that the delusion must be present for at least 3 months (World Health Organization, 2016).

The DSM-5 and the ICD-10 both allow for specification of a subtype within delusional disorder. The DSM-5 subtypes are:

› The grandiose subtype central delusion revolves around having a great talent or insight that is not recognized, or having made an important discovery

› The erotomanic subtype features a delusion with a central theme of being loved by someone who usually is of higher status. Direct contact may or may not be attempted

› The jealous subtype involves a belief based on small pieces of information that are interpreted as evidence that a partner, lover, or spouse is unfaithful

› The persecutory subtype involves a central theme of being conspired and plotted against. Small slights are exaggerated, and the delusion might lead to legal proceedings or in some cases to violence to obtain redress

› The somatic subtype involves delusions centered on bodily functions or sensations. Beliefs might include a conviction that one emits a foul smell or that body parts are not functioning
Mixed subtype is used when no single delusional theme predominates
Unspecified subtype is used when the central delusion is not described in a specific subtype or cannot clearly be determined
In addition to the above subtypes the ICD-10 includes litigious and self-referential subtypes

Despite being a common feature of bipolar disorder diagnoses and schizophrenia diagnoses, delusions of the grandiose subtype are not common among delusional disorder diagnoses. Grandiose delusions are characterized by a central delusion of having a great talent or insight that is not recognized or having made an important discovery. They may also include convictions of having inflated worth, knowledge, power, or a special identity (Brusie, 2017), symptoms which may overlap with those of narcissistic personality disorder. Grandiose delusions seem to be held with greater conviction than any other type of delusion, although they are the least often acted upon. In a study of persons with grandiose delusions they performed significantly worse on theory of mind tasks (the ability to accurately attribute beliefs, intentions, or mental states to others) than the control group (Boyden et al., 2015).

The two most extensively researched causes of grandiose subtype delusions are the delusion as defense theory and the emotion-consistent theory. The delusion as defense theory asserts that grandiose delusions are compensation for a sense of loneliness, unworthiness, or powerlessness, and may be the result of a life event that caused feelings of failure or worthlessness. The emotion-consistent theory suggests that grandiose delusions grow out of elevated self-esteem combined with uncritical or even faulty cognitive and information perception and processing, which contributes to elevating self-esteem to the level of delusion.

The etiology of delusional disorder is unknown. Research is difficult because the definition of the disorder has changed over time, those in whom it is diagnosed often avoid treatment and therefore are not included in research studies, and the diagnosis is unstable because of the presence of delusions in psychotic and mood disorders. Onset is usually insidious. Typically, the course has less deterioration than other psychotic disorders, symptoms may wax and wane, and there may even be periods of full remission. Generally only functioning directly associated with the central delusion is impaired by the disorder, with negative outcomes associated with actions resulting directly from the central delusion. Depression is the most common co-occurring diagnosis. Treatment might include mental health medications appropriate to the symptoms, social skills training, psychoeducation about delusional disorder, and individual therapies such as cognitive-behavioral therapy depending on the impact of delusions on functioning and the nature of the central delusion.

**Facts and Figures**

Because there are few diagnosed cases of delusional disorder, most studies are individual case studies. DSM-5 places lifetime prevalence at 0.2%. The limited research suggests that the mean age of onset is 40, with a range from 18 to 90 years old (American Psychiatric Association, 2013). Delusional disorder is found in slightly more women than men; among subtypes, persecutory is the most common, jealous the next most common, and grandiose, erotomanic, and somatic the most rare. At long-term follow-up, 50% of study participants with delusional disorder had recovered, 20% had decreased symptoms, and 30% showed no signs of change (Sadock et al., 2015). Women are more likely to develop erotomanic delusions and men are more likely to develop paranoid delusions (Sadock et al., 2015). Approximately 20% of clients with a diagnosis of delusional disorder develop schizophrenia (Opjordsmoen, 2014).

An analysis of a clinical sample of 275 patients in Spain in whom delusional disorder (132) or schizophrenia (143) had been diagnosed confirmed distinct characteristics for the two groups. Those with delusional disorder were on average older (50 years old versus 36 years old), were more likely to be (or to have been) married or living with someone (67% versus 20%), and were less likely to be unable to maintain employment (29% versus 59%) than those with schizophrenia (Munoz-Negro, 2017).

**Risk Factors**

The etiology of delusional disorder is unknown; however, genetic, biological, psychological, and environmental factors may play some role in its development. Risk factors depend on the nature of the central delusion and therefore may appear to be contradictory. Risk factors may include social isolation; sensory perception impairment; perfectionist parenting; cruel, erratic, or unreliable parenting; low socioeconomic status; recent immigration; celibacy among men; and widowhood among women.

**Signs and Symptoms/Clinical Presentation**

Signs and symptoms vary depending on the central delusion; however, there are common elements. Persons are usually well groomed with good hygiene and no evidence of gross impairment; their cognition and memory are typically within normal range as measured by mental status examinations; and they have little or no insight into their delusional state. Their mood and affect may reflect delusional content (e.g., persons with the persecutory subtype may be suspicious or anxious) and they may experience hallucinations (e.g., persons with the somatic subtype may have the sensation of being infested by insects).
Social Work Assessment

› Client History
  • Complete a standard biopsychosocial-spiritual history, including risk for suicide and harm to self or others
  • Observation of current functioning and demeanor
  • Collecting collateral information from family, friends, and coworkers is especially important because persons frequently have limited insight into their delusions
  • Explore prior diagnosis of mental health disorders that included delusions
  • Assess for alcohol and drug consumption, including legal, illegal, prescribed, and nonprescribed drugs

› Relevant Diagnostic Assessments and Screening Tools
  • Peters et al. Delusions Inventory
  • Paranoia Checklist
  • MacArthur-Maudsley Assessment of Delusions Schedule (MMADS)
  • Simple Delusional Syndrome Scale (SDSS)
  • Brown Assessment of Beliefs Scale (BABS)

› Laboratory and Diagnostic Tests of Interest to the Social Worker
  • Appropriate medical tests to rule out medical conditions
  • Appropriate tests for substances to eliminate substance use as the cause of the delusion

Social Work Treatment Summary

Treatment of delusional disorder can be challenging because persons commonly deny that their delusions are not real and because they often avoid treatment. Persons who enter treatment may continue to be suspicious of treatment; thus the development of a therapeutic alliance can be difficult.

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

Individual psychotherapy is preferred to group therapy; and, even more than with other clients, being steadfast, reliable, and maintaining professional boundaries is important in building trust. Although the central delusion must be acknowledged and described, avoid directly challenging it or making it the central point of discussion. Psychosocial treatments that are solution focused and provide social skills training are more effective than insight-oriented approaches. Cognitive behavioral therapies designed specifically for delusional disorder are effective. Medication may also be beneficial; however, the client may be resistant to or suspicious of a referral for a medication evaluation.

Social workers should practice with awareness of and adherence to the social work principles of respect for human rights and human dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles, as well as the national code of ethics that applies in the country in which they practice (IFSW, 2012). For example, in the United States, social workers should adhere to the National Association of Social Workers (NASW) Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. They should become knowledgeable of the NASW ethical standards as they apply to delusional disorder–grandiose type and practice accordingly (NASW, 2015).

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Disruption of daily life or functioning due to impact of delusions (e.g., depression)  | Reduce symptoms to restore full functioning and to stabilize client so that underlying delusion can be addressed in therapeutic treatment  | Schedule appointment with mental health professional who can prescribe appropriate medications.
Follow up on medication adherence, including discussion of side effects and of importance of adhering to prescription dosage and timing; clinician and client should note changes in behavior to report on follow-up visits

Denial that delusion is a delusion, inappropriate social behavior congruent with delusion  | Acceptance that delusion is a delusion and understanding of appropriate social behavior; reduction in behavior caused by delusional beliefs  | Psychoeducation focused on education about the nature of delusional disorder and social skills training to recognize and decrease behavior inspired by the delusion

Delusional thinking and beliefs  | Restore reality-based thinking and beliefs  | Individual psychotherapy based on a strong therapeutic alliance or cognitive-behavioral therapy targeting thought patterns that reinforce delusional beliefs

**Applicable Laws and Regulations**


Each jurisdiction (e.g., nation, state, province) has its own standards, procedures, and laws for involuntary restraint, detention, and reporting of persons who may be a danger to themselves or others. Violence toward perceived persecutors may occur in persecutory, erotomanic, and jealous subtypes of delusional disorder. Law violations related to the central delusions may occur in other subtypes. Persons with the persecutory subtype may bring lawsuits related to the central delusion.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in the United States provides privacy rights and protections to clients with mental health issues. HIPAA recognizes the important role that family and friends play in a client’s life and the healthcare provider can communicate with family members if the client does not object. Information may also be shared when the client is incapacitated and/or the healthcare professional determines that it is in the best interest of the client to provide family members with information that is directly related to the client’s care or payment for care. The client must provide authorization for psychotherapy notes to be shared unless disclosure is required by law (i.e., mandated reporting of abuse, duty to warn, imminent harm).

Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (e.g., National Association of Social Workers in the United States, British Association of Social Workers in England) and practice accordingly.

**Applicable Services and Resources**

Enter “delusional disorder” in the search box to access relevant information available on each website.
Food for Thought

» Brain structural abnormalities are found in persons with delusional disorder (Vicens et al., 2016)
» Delusional disorder has not been investigated using large community-based samples, making attempts to establish accurate prevalence rates difficult
» Most persons with delusional disorder do not appear impaired

Red Flags

» Persons with delusional disorder may be at risk for suicide
» Assess for likelihood of harming others and access to weapons
» Directly confronting delusional belief(s) has little impact and may instead strengthen the belief(s)
» Frequently the only sign of the disorder is the delusion itself and behavior directly related to the delusion

Discharge Planning

» Review medication regimen and make follow-up appointment with agency issuing prescription
» Discuss importance of medications and taking them as prescribed, as well as how to deal with side effects of medications
» Assess stability of living situation and make referrals as appropriate
» Provide referrals for support to family members
» Refer to transitional support services or case management, if available and acceptable to the client, to facilitate linkage to follow-up care, community resources, and benefits/entitlements

DSM-5 Codes

» 297.1 – Delusional Disorder

References