Developed central delusional theme from which conclusions are deduced, the delusions are called systematized. Of people experiencing delusions, 90% have concurrent hallucinations.

Delusions are believed to be caused by dysfunction in the information-processing circuits within and between the brain’s two hemispheres. Studies demonstrate a positive correlation between the degree of reality distortion and activity in the medial temporal and ventral limbic areas. Delusions occur in schizophrenia, delusional disorder, depression with psychotic features, bipolar disorder, anorexia, obsessive–compulsive disorder, body dysmorphic disorder, hypochondriasis, and dementia. As with hallucinations, the severity of delusions can be a valuable indicator in monitoring the course of a mental disorder (Blackwood et al., 2001).

### Types of Delusions

There are a number of delusional types. Grandiosity, also known as delusions of grandeur, is an exaggerated sense of importance or self-worth. It is often accompanied by beliefs of magical thinking, when a person believes that thinking about a possible occurrence can make it happen. Delusions of control occur when the person believes that feelings, impulses, thoughts, or actions are not one’s own but are being imposed by some external force. Erotomanic delusions are beliefs that a person, usually someone famous and of higher status, is in love with the person. Somatic delusions occur when people believe something abnormal and dangerous is happening to their bodies. Ideas of reference are remarks or actions by someone else that in no way refer to the person but that are interpreted as related to her or him. Thought broadcasting occurs when people believe that others can hear their thoughts. Thought withdrawal is the belief that others are able to remove thoughts from one’s mind. Thought insertion is the belief that others are able to put thoughts into one’s mind.

Religious delusions involve false beliefs with religious or spiritual themes. Religious ideas that may appear delusional in one culture may be commonly held in another. It is important that the nurse distinguish religious beliefs and experiences from delusional psychotic symptoms. Delusions in psychotic episodes:

- Are more intense than usual experiences in a person’s religious community
- Are often terrifying for the person
- Involve obsessional preoccupation with the delusion
- Are associated with deterioration of self-care and social skills
- Often involve special messages from religious figures

Delusions of persecution involve beliefs that someone is trying to harm the person. These delusions are preoccupying, obtrusive, and distressing to the client. The danger is that clients will act on their delusional beliefs, harming others in an attempt to protect themselves. People with persecutory delusions are hypervigilant to threat-related stimuli. When things are going well for them, clients are convinced it is their own doing. When things go badly, they are convinced that it is the fault of other people who are “out to get them.” They are preoccupied with the intentions of others. It is hypothe-