CHAPTER 2

LITERATURE REVIEW

2.2 Concept of Delusions

2.2.1 Definition of Delusion

Delusions are false beliefs that are inconsistent with reality and arise from the misinterpretation of external reality, despite the presence of evidence contradicting those beliefs. Such beliefs are generally inconsistent with the cultural norms or subculture in which an individual lives; therefore, they are regarded by most people as false or unfounded (Putra et al., 2019).

Delusions are diagnosed as a mental disorder when an individual experiences one or more non-bizarre delusions that is, false beliefs involving situations that could plausibly occur in real life which persist for at least one month and cannot be better explained by another medical condition or mental disorder. In establishing the diagnosis, an individual's cultural background should be taken into consideration, as cultural values and beliefs may influence both the content and the form of the delusions (Putra et al., 2019).

Individuals with delusional disorder may believe that they are being pursued by tax authorities, a type of delusion that, although false, remains plausible in real life and is therefore classified as a non-bizarre delusion. In contrast, individuals with schizophrenia may experience more implausible beliefs, such as believing that they are being pursued by a "metal horse," which is considered a bizarre delusion. Charlton and McClelland explained that individuals with delusional disorder typically misinterpret the motives or actions of others; however, their subsequent thought processes generally remain logical and systematic. This differs from other mental

disorders accompanied by delusions, in which thought processes are often illogical and difficult to comprehend (Putra et al., 2019).

Delusions are defined as false beliefs that are inconsistent with reality, are firmly maintained by the patient, and cannot be altered through logical reasoning or persuasion by others. These beliefs arise from disturbances in the patient's thought processes, resulting in a loss of cognitive control (Dermawan & Rusdi, 2013).

2.2.2 Etiology

The exact cause of delusional disorder has not yet been clearly established. Various biological factors, including substance use, underlying medical conditions, and neurological disorders, are known to contribute to the development of delusions. From a neurobiological perspective, delusional disorder is thought to be associated with dysfunction of the limbic system and the basal ganglia, which play important roles in emotional processing, perception, and the interpretation of environmental stimuli (Putra et al., 2019).

Individuals with delusions experience impairments in the brain's ability to generate predictions and interpret incoming information and experiences. Discrepancies between expectations and actual experiences may lead to errors in interpreting events, resulting in the formation of beliefs that are inconsistent with reality. This condition is believed to be associated with the activity of the neurotransmitter dopamine in brain regions involved in the reward system and information processing (Putra et al., 2019).

In patients with persecutory delusions accompanied by fear, individuals frequently interpret situations or the behavior of others as threats to their safety. Consequently, they develop false beliefs that they are being watched, followed, harmed, or deliberately targeted by others despite the absence of objective evidence

supporting these beliefs. Persistent feelings of fear may further reinforce these delusional beliefs, making it increasingly difficult for individuals to distinguish between reality and their distorted perceptions (Putra et al., 2019).

From a psychodynamic perspective, individuals with high emotional sensitivity who rely on ego defense mechanisms, such as projection, denial, and reaction formation, are more susceptible to developing delusional disorders. In addition, psychosocial factors including social isolation, distrust of others, excessive suspiciousness, jealousy, and low self-esteem may contribute to the development of delusions. When these emotional experiences cannot be managed through adaptive coping mechanisms, individuals tend to construct explanations that they perceive as rational. Consequently, delusions may develop as a means of making sense of and interpreting their experiences (Putra et al., 2019).

According to Keliat (Damaiyanti & Iskandar, 2014), there are two major factors that contribute to the development of delusions:

a. Predisposing Factors

   Predisposing factors include developmental, sociocultural, psychological, genetic, and biochemical factors. Disruptions in developmental tasks may lead to stress and anxiety. Various sociocultural factors may cause individuals to experience social isolation and loneliness, resulting in reduced external stimulation. Excessive stress may also disrupt the body's metabolic processes, leading to impaired processing of both internal and external stimuli.

b. Precipitating Factors

   Environmental stimuli frequently serve as precipitating factors for the development of delusions. These may include poor interpersonal relationships, prolonged conversations, certain environmental objects or stimuli, and social

isolation or a quiet environment. Such conditions may increase an individual's levels of stress and anxiety, thereby contributing to the onset or exacerbation of delusional symptoms.

2.2.3 Continuum of Respons

According to Damaiyanti (2012), the continuum of responses in delusions is

Table 2. 1 Response range of delusion Darmiyanti (2012).

Adaptive Responses ⟷ Maladaptive Responses

LOGICAL THINKING	THOUGHT DISORIENTATION	DISTURBED THOUGHT PROCECESSES/DELUSIONS
Accurate perception	Illusions	Difficulty responding appropriately
Consistent emotional responses	Exaggerated or diminished emotional reaction	Inappropriate behavior
Appropriate social behavior and interpersonal relationships	Odd or unusual behavior; social withdrawal	Social isolation ; hallucination

2.2.4 Types of Delusions

Based on the definitions presented above, delusions are false beliefs that are inconsistent with reality and continue to be firmly maintained by the individual despite evidence to the contrary. Most delusions involve beliefs that are illogical or implausible. According to Kusumawati and Hartono (2012), delusions can be classified into several types, including religious delusion: a client's excessive religious conviction.

a) Religious Delusions: False beliefs characterized by an excessive conviction regarding religious matters or one’s relationship with religion

b) Grandiose Delusions: False beliefs involving exaggerated perceptions of one's importance, power, abilities, wealth, or identity.

c) Paranoia Delusions: False beliefs that one's body, or part of the body, is affected by a disease or that foreign organisms or object are present within the body.

d) Persecutory Delusions: False beliefs that an individual or a particular group intends to harm, persecute, or injure the person.

e) Nihilistic Delusions: False beliefs that one no longer exist or is already dead.

f) Bizarre Delusions Bizarre delusions include the following:

- Thought Insertion: The false belief that another person's thought have been inserted into one's own mind.
- Thought Broadcasting: The false belief that other people are aware of one's thought, even though they have never been expressed verbally.
- Thought Control: The false belief that one's thought are being controlled by external force.

2.2.5 Clinical Manifestations

According to Yusuf, Fitryasari, and Nihayati (2015), patients with delusions may exhibit various clinical manifestations involving cognitive, affective, behavioral, social, and physical aspects.

a. Clinical Manifestations

From a cognitive perspective, patients experience disturbances in reality testing, making it difficult to distinguish between reality and fantasy. They tend to firmly maintain their false beliefs despite evidence to the contrary. In addition, their ability to think realistically is impaired, and their decision-making processes are often ineffective or compromised

b. Affective Aspect

The affective manifestations are characterized by emotional responses that are inconsistent with the actual situation. Patients may also exhibit blunted affect, which refers to a reduced or limited emotional expression compared with normal emotional responsiveness.

c. Behavioral and Social Realtionship Aspects

In terms of behavior and social interaction, clients often exhibit extreme sensitivity to their surroundings. Interpersonal relationships with others tend to be disrupted due to a lack of trust and excessive suspicion. Clients may also experience feelings of sadness or depression, hesitation in taking action, and a tendency to make verbal threats. In addition, they may exhibit behavior that is inappropriate for the situation, repetitive actions without a clear purpose (stereotyped behavior), impulsive behavior, and a tendency to be easily suspicious of others.

d. Physical Aspects

Common physical manifestations include a decline in personal hygiene, a pale complexion, frequent yawning, weight loss, decreased appetite, and sleep disturbances or difficulty sleeping. In clients with delusions of suspicion accompanied by fear, these physical symptoms may become more pronounced due to the constant anxiety and excessive vigilance they experience.

2.2.6 Pathophysiology

The process of becoming delusion according to Yusuf, Fitryasari, and Nihayati (2015) is as follows:

a. Its Limited Phases

Lack of Human Need The occurrence of delusion begins with the limited range of patients' needs physically and psychologically. Physically, discourse

can occur in individuals with limited social and economic status. The client feels suffering. The client may be compensating incorrectly due to a gap between reality and what is expected.

b. Its Low Phase

Lack of Self Esteem everyone must have a self-ideal that they form according to their desires and needs, for example the desire for the fulfillment of needs. When needs are not met, there can be a gap between one's ideal and what the individual experiences, then the individual will feel suffering, shame, and worthless.

c. Control Phase

Internal and External Control In this phase, the client tries to think rationally what is believed to be a lie, just to cover up the flaws, and does not correspond to reality. However, facing reality for clients is a tough thing because the need to be recognized, considered important, and accepted by the environment becomes a priority in life. The environment around the client tries to give an assessment that what the client says is not true, but this is not done adequately because of the amount of tolerance and desire to become feelings. The environment is only a passive listener but does not want to contradict for a prolonged period of time on the grounds that what the client believes is not harmful to others.

d. Support Phase

Environment Support A supportive environment that believes what the client believes causes the client to feel supported, so that the patient considers what he believes to be the truth because it is often repeated. Therefore, there began

to be a breakdown of self-control and the malfunction of the superego which was characterized by no longer feeling guilty when lying.

e. Comforting Phase

In this phase, the client is comfortable with his beliefs and lies and assumes everyone will trust and support him. Conviction is often accompanied by hallucinations when the client is alone from his or her environment. Furthermore, clients are more likely to be alone and avoid social interactions.

f. Improvement Phase

When the client is a person who has experienced a comforting phase and feels supported by the environment because no one confronts his beliefs, then the client will enter this phase of improvement.

2.2.7 Management

Management of patients with thought process disorders: delusion requires a comprehensive approach through pharmacological and non-pharmacological therapies. One of the nonpharmacological interventions that can be applied is Reality Orientation Therapy combined with the principle of Skinner's Operant Conditioning**.** The combination of these two approaches aims to help patients improve their ability to recognize reality while strengthening adaptive behavior through consistent reinforcement.

Behaviors that are followed by pleasant consequences (positive reinforcement) will tend to be repeated, while behaviors that do not gain reinforcement will decrease in frequency. In the context of the patient of the waking patient, the behavior that is in accordance with reality is given a positive reinforcement so that the ability to orient reality is increasing, while the content of the reality is not strengthened so that the frequency can be gradually reduced. (Skinner, 2021).

Research by Anggriani and Rahmawati (2025) shows that reality-oriented therapy is effective in improving patients' ability to recognize reality and help control symptoms of disorientation. Behavioral reinforcement through positive reinforcement has also been shown to increase the success of behavioral therapy in patients with mental disorders.

2.3 The Concept of Reality Orientation Therapy

2.3.1 Definition of Reality Orientation Therapy

Reality Orientation Therapy is the client's inability to assess and respond to reality. Patients cannot distinguish daydreams and reality (Kusunawati, 2012). Reality Orientation Therapy is an attempt to orient real circumstances to the patient, namely oneself, others, the environment or place and time. Patients with psychotic mental disorders experience a decrease in reality testing ability. The patient no longer recognizes the place, time and people around him. This can cause the patient to feel unfamiliar and become a trigger for anxiety. To overcome this obstacle, there needs to be activities that provide consistent stimulation to patients about the reality around them. The stimulus includes the reality of the environment, namely oneself, others, time and place (Kusunawati, 2012).

2.3.2 Reality Orientation Therapy Objectives

According to (Kusunawati, 2012) the goal of Reality Orientation Therapy is to help its members relate to others and change destructive and maladaptive behaviors. Groups serve as a place to share experiences and help each other find ways to solve problems.

1. General objective: The general objective of Reality Orientation Therapy is that the patient is able to recognize people, places and times according to reality

2. Special Objectives: The Special Objectives of Reality Orientation Therapy are:
    - The patient is able to know where he is and has been.
    - Patients know the time precisely
    - Patients can get to know themselves and those around them appropriately

      It can be concluded that the functions of Reality Orientation Therapy include:
    - Seek the patient to identify internal stimuli (thoughts, feelings, somatic sensations) and external stimuli (climate, sound, environmental situation)
    - Can distinguish between daydreams and reality
    - Can speak according to reality
    - Able to know oneself and others, time and place

2.3.3 Reality Orientation Therapy Implementation Procedure

According to Yalom cited by Stuart and Sundeen, 2021, the phases in group activity therapy are as follows:

a) Pre-Group

   Begins with making goals, planning, who will be the leader, members, where, when the group activities will be carried out, evaluation process on members and groups, explaining the resources needed by the group such as projectors and if possible costs and finances.

b) Early phase

   In this phase, there are 3 possible stages that occur, namely orientation, conflict or togetherness.

1. Orientation Members

   begin to develop their own social systems, and leaders begin to show therapy plans and take contracts with members.

2. Conflict

   It is a difficult time in the group process, members begin to think about who is in power in the group, what the role of the members is, their duties and the interdependence that will occur.

3. Togetherness

   Members begin to work together to solve problems, members begin to discover who they are.

4. Work phase

   At this stage, the group has become a team. Positive and negative feelings are corrected with trusting relationships that have been fostered, working together to achieve agreed goals, decreased anxiety, groups are more stable and realistic, exploring further according to the group's goals and tasks, and creative problem-solving.

2.4 Concept Operant Conditioning Skinners

Operant Conditioning is a learning theory developed by Burrhus Frederic Skinner. This theory explains that human behavior can be shaped through the consequences that follow that behavior. Skinner stated that behaviors that gain reinforcement will tend to be repeated, while behaviors that do not gain reinforcement will be less frequent (Antoni, 2024).

2.4.1 Basic Concept Operant Conditioning Skinners

1) Reinforcement

   a) Positive Reinforcement

      Provides a pleasant stimulus after the behavior appears.

      Example:

      - Praise
      - Smile
      - Awards
      - Caution

   b) Negatif Reinforcement

      Eliminate unpleasant stimuli after the expected behavior appears.

2) Punishment

   Punishment is a consequence given to reduce unexpected behavior.

3) Extinction

   Extinction is the cessation of reinforcement so that the behavior will gradually decrease.

4) Shaping

   Shaping is a process of forming behavior gradually through the provision of reinforcement on each progress achieved.

2.4.2 Application of Operant Conditioning in Delusion Patients

In psychiatric nursing care, positive reinforcement is given when the patient:

1. Stating one's identity correctly.
2. Recognize the time and place.
3. Revealing facts according to reality.
4. Interact with the environment adaptively.

On the other hand, the content of the delusion is not strengthened so that gradually the frequency of the appearance of the delusion can decrease.

2.5 Concept of Nursing Care

According to Stuart (2016) the concept of nursing care is described as follows:

2.5.1 Assessment

The assessment of self-concept in patients is one of the important aspects as well as a challenge for nurses, because self-concept, especially low self-esteem, is the basis for the formation of a person's personality. This condition is often related to the appearance of anxiety, depression, interpersonal relationship disorders, and behaviors that can be self-harming. The assessment process begins with the assessment of predisposing factors, presification, response to stressors, coping sources as the ability to overcome problems and coping mechanisms as efforts used by individuals to solve problems (Stuart, 2013).The stress adaptation model of Stuart (2016) regarding mental health nursing care is:

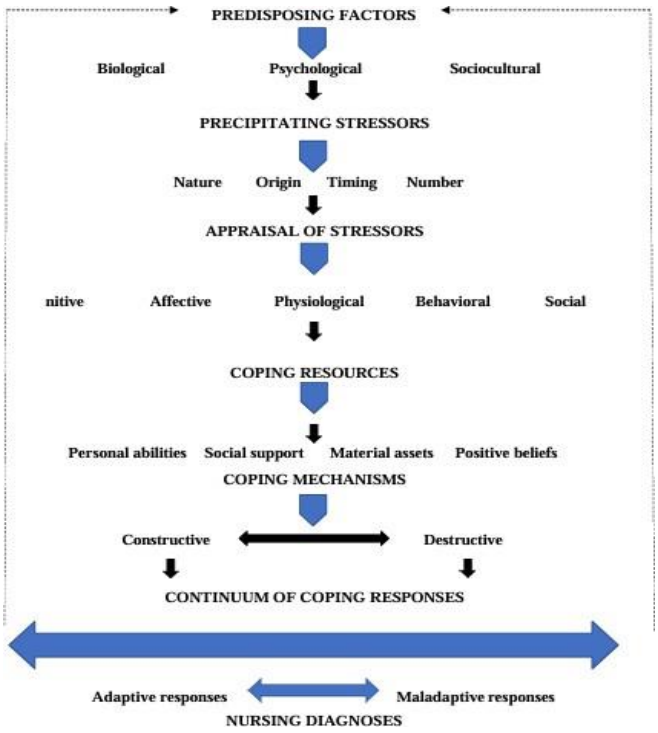


Figure 2. 1 Model Adaptasi Stress Stuart (2016)

In conducting the assessment, the nurse not only focuses on the objectively apparent behavior, but also needs to understand the subjective experience and internal conditions that the client perceives. The assessment begins with observation of the client's appearance, including posture, personal hygiene, makeup, and how to dress. In addition, the nurse can discuss the appearance with the client to find out the values they have regarding their body image. Observations of diet, sleep, and personal hygiene habits can also provide information about the client's biological condition and self-care ability.

The data obtained from this assessment process can help nurses understand the client's self-concept condition more deeply and become the basis for determining appropriate nursing interventions.

1) Predisposing factors

Predisposing factors are various conditions that act as risk factors and protective factors that affect an individual's ability to adapt to stress. These factors include biological, psychological, and sociocultural dimensions, which can affect a person's vulnerability to mental health disorders as well as their ability to maintain mental health Stuart and Sundeen (2013).

1. Biological factors that act as predisposing factors include various conditions that can increase an individual's susceptibility to health problems, such as genetic or hereditary history, nutritional status, biological sensitivity, general health conditions, and exposure to harmful substances or toxins in the environment.
2. Psychological factors include various aspects that affect an individual's ability to cope with stress and adapt to the environment. These factors include the level of intelligence, verbal communication skills, moral

values, personality characteristics, previous life experiences, self-concept, motivation, psychological defense mechanisms, and locus of control, which is an individual's belief about the extent to which he is able to control events or conditions that occur in his or her life.

3. Socioculture includes various characteristics and conditions related to a person's social environment, such as age, gender, level of education, income, occupation, position or status in society, culture adhered to, religious values and beliefs, involvement in political activities, socialization processes and experiences, and the degree of relationships and attachment to others in the social environment.

2) Precipitation factors

Precipitation factors are various stimuli or events that are perceived by individuals as a challenge, threat, or demand that requires additional coping skills to deal with them. These factors can come from individual health conditions, environment, attitudes, and behaviors that have the potential to trigger the onset of psychosocial problems. If individuals are not able to manage the stressors they face effectively, the risk of mental health disorders will increase. The precipitation factor consists of several stressor components that play a role in triggering the emergence of maladaptive responses in individuals Stuart and Sundeen (2016).

a) Stressor Traits

Stressor traits can be grouped into three main aspects, namely biological, psychological, and social. These three aspects emerged in response to threats that affect the physical integrity and self-concept of the individual. Biological stressors are threats to physical conditions that can hinder a person's ability to

carry out daily activities due to a decrease in physiological function or certain health conditions (Videbeck, 2014).

Threats to physical integrity can come from internal as well as external factors. Internal factors include disturbances in the body's physiological mechanisms, such as disorders of the cardiovascular system, immune system, and body temperature regulation. Meanwhile, external factors include exposure to viral or bacterial infections, environmental pollution, threats to security, and lack of fulfillment of basic needs such as food, clothing, and traumatic experiences (Stuart, 2016). Psychological and sociocultural stressors are generally related to threats to individual self-esteem, self-identity, and social functioning.

b) Sources of Stressors

The source of the stressor can come from within the individual (internal) or from the external environment (external). Internal sources include negative perceptions of oneself, others, and the surrounding environment, as well as physical health conditions experienced by individuals. Meanwhile, external sources can be in the form of a lack of social support, interpersonal conflicts, or unpleasant social experiences that cause psychological distress.

c) Time and Duration of Stressors

The time and duration of exposure to stressors are factors that affect the appearance of psychosocial problems. Stressors can occur over a short period of time, last for a long period of time, or appear repeatedly. The longer and more often an individual is exposed to stressors, the greater the risk of impaired coping and coping skills.

d) Number of Stressors

The number of stressors experienced by individuals in a given period also plays a role as a precipitation factor. The accumulation of various experiences that cause stress can increase the psychological burden of individuals so that it affects the ability to deal with problems and adapt effectively to the situation at hand.

3) Stressor Trigger

Stress emotion is a variety of stimuli that individuals perceive as challenges, threats, or demands that require additional effort and energy to deal with them. These conditions can cause tension and stress responses in individuals. Stress-triggering factors can come from biological, psychological, and sociocultural aspects, and can come from the individual's internal and external environment. In examining precipitation factors, it is important to pay attention to the time dimension which includes when stressors begin to appear, the length of time individuals are exposed to stressors, and how often the stressors occur. In addition, the number of stressors experienced in a given period also needs to be considered. The more stressful events occur in close proximity, the greater the burden that individuals must face, so coping and adaptability can become less effective. According to Stuart (2016), individual responses to stressors can be divided into five aspects, namely cognitive, affective, physiological, behavioral, and social responses.

1. Cognitive Response

Cognitive responses function as mediators in the interaction between individuals and their environment (Stuart, 2016). Through cognitive processes, individuals assess the stressors they are facing, including

determining whether the stressor is a threat or not. The assessment is influenced by several factors, including:

a) An individual's perception and understanding of stressors, such as openness to accepting change, active involvement in various activities, and the ability to control oneself against environmental influences.
b) The availability of resources that support an individual's ability to tolerate and adapt to stress, both from oneself and the surrounding environment.
c) The coping ability is generally influenced by previous experience in dealing with various stressful situations.
d) The effectiveness of coping strategies used to overcome problems or pressures faced (Stuart, 2016).

2. Affective Response

Affective responses are related to the emotional reactions that arise when individuals face stressors.

a) Emotional expressions can be in the form of feelings of sadness, joy, fear, anger, acceptance, disbelief, anticipation, or surprise.
b) The type, duration, and intensity of emotions that arise depend on the characteristics of the stressors experienced as well as the individual's experiences over time.
c) Mood is an emotional condition that lasts for a relatively long time and can affect a person's feelings and behavior.

d) Attitudes can be formed when stressors last for a long period of time so that they become a certain pattern of response or habits in individuals (Stuart, 2016).

3. Physiologist Response

   Physiological responses involve a variety of body systems, including the neurological, hormonal, anatomical, and neurochemical systems. In the face of stress, the body will activate a fight or flight response controlled by the autonomic nervous system. This activation also stimulates the work of the pituitary and adrenal glands so that the body is better prepared to face the threat or pressure felt (Stuart, 2016).

4. Behavioral Response

   Behavioral response is a tangible form of the results of an individual's cognitive and affective assessment of the stressor faced (Stuart, 2016). Behavioral changes can appear as an effort to adapt to stress. However, if the individual is unable to make an appropriate assessment of the stressor or fails to control his physiological response, maladaptive behavior or inappropriate behavior can appear.

5. Response: Social

   Social response is concerned with an individual's ability to interact with others and the surrounding environment. When a stressor is perceived as a threat or danger, individuals may show increased alertness that affects their social relationships. Therefore, social responses reflect how a person maintains social functions, builds interpersonal relationships, and adjusts to the environment in stressful situations (Stuart, 2016).

4) Coping Source

Coping resources is a protective factor that helps individuals in dealing with and coping with various stressors that arise in life. These resources include economic assets, individual abilities and skills, social support, and motivation. Other resources that support the coping process include good health, adequate energy, spiritual support, positive beliefs, problem-solving skills, social skills, availability of social and material resources, and overall physical well-being.

1. Spiritual beliefs can be a foundation of hope and strength for individuals in the face of difficult situations, thus helping to maintain coping skills even in unfavorable circumstances.
2. Problem-solving skills include the skills to search for relevant information, recognize and analyze problems, consider alternative solutions, and make and execute appropriate decisions to address the problem.
3. Social skills play a role in helping individuals solve problems that involve interaction with others. These skills can also increase the chances of gaining support, cooperation, and strengthen the individual's ability to control the social situations they face.
4. Material resources include financial ownership, goods, and services that can be obtained through economic resources. The availability of adequate economic resources can expand the choice of coping strategies that can be used in dealing with a variety of stressful situations.
5. In addition, knowledge and intelligence levels are also important coping resources because they allow individuals to better understand problems and identify effective ways to solve them.

6. Other factors that can support coping skills include a strong self-identity, involvement in positive social networks, cultural stability, consistent value and belief systems, and orientation towards health maintenance and disease prevention. All of these factors play a role in improving the individual's ability to adapt effectively to life's various pressures and challenges.

5) Coping mechanism

According to (Keperawatan et al) At this stage, the individual begins to use Coping mechanism as an effort to deal with and manage the stress they experience. This stage is an important moment for nurses to undertake interventions that focus on primary prevention to help individuals develop adaptive responses to stressors. The coping mechanism can be interpreted as various efforts made by individuals to overcome pressure or stress, which can be adaptive (constructive) or maladaptive (destructive). In general, there are three main types of coping mechanisms, namely:

1. Problem-Focused Coping

   Coping mechanism is directed at a direct attempt to address or change the source of the problem that causes stress. Individuals seek to find solutions through concrete actions to reduce or eliminate the threats faced. Examples of strategies included in problem-focused coping are negotiation, constructive confrontation, and seeking information, help, or advice from others.

2. Cognitive-Focused Coping

   In this mechanism, individuals try to change their perspective or assessment of problems so that the impact of perceived stress can be reduced. The strategies used include positive thinking, comparing one's

condition with a more difficult situation, selectively ignoring certain information, looking for other sources of satisfaction as a substitute, and reducing the value or importance of objects or goals that are difficult to achieve.

3. Emotion-Focused Coping

   This coping mechanism aims to reduce the emotional tension that arises due to stressors. Individuals attempt to manage uncomfortable feelings through a variety of means, including the use of ego defense mechanisms. Some forms of defense mechanisms that are often used include denial, repression, and projection, which serve to reduce anxiety and maintain psychological balance.

6) Behavior

According to (Keperawatan et al) Mental disorders in general can be grouped into Neurotic disorders and Psychotic disorders. Neurotic disorders are characterized by the presence of one or more symptoms that cause discomfort to the individual, where the individual is still aware that the symptoms he is experiencing are unnatural and disturbing to him. In this condition, the individual's ability to assess and understand reality is still maintained. Although daily functioning can be disrupted, the behavior shown generally still conforms to the prevailing social norms. In addition, neurotic disorders usually last for a long time or recur if they are not treated properly, and are not caused by obvious organic disorders.

However, when individuals face conflict or intense stress, the ability to assess reality can be impaired so that it develops into a psychotic disorder. Psychotic disorders are characterized by the appearance of regressive behavior,

disorganization or disintegration of personality, a decrease in meaningful awareness, and severe disturbances in carrying out daily life functions. One of the main characteristics of psychotic disorder is a decrease in the ability to test reality, so that individuals have difficulty distinguishing between reality and their own perceptions.

As a result of these disturbances, individuals may have perceptions that do not correspond to real conditions and draw erroneous conclusions about the surrounding environment, despite evidence to the contrary. Manifestations that are often found in psychotic disorders are the appearance of delusions and hallucinations, in which individuals are unaware that the experience they are experiencing is part of a disorder. Therefore, psychotic disorders are considered a more severe form of psychiatric disorder because they cause significant impairment in an individual's cognitive, emotional, behavioral, and social functioning.

2.5.2 Nursing Diagnoses

According to (SDKI DPP PPNI Working Group Team, 2017), nursing diagnosis is a clinical assessment carried out by nurses on the response of individuals, families, or communities in dealing with health problems and ongoing life processes, both actual and at risk of occurring. Nursing diagnosis aims to identify a range of client responses to the health condition experienced, so that it can be the basis for planning and delivering appropriate and targeted nursing interventions. It is in patients with nursing problems that the most likely nursing diagnoses that arise are:

1. Social Isolation (D.0121)
2. Sensory Perception Disorders: Auditory Hallucinations (D.0084)
3. Chronic Low Self-Esteem (D.0086)

4. Risk of Violent Behavior (D.0146)

2.5.3 Nursing Output

Nursing outcomes are changes in the client's health condition that can be observed and measured, both in terms of behavior, perception, and response of the client to the nursing intervention that has been given. These outputs are indicators of the success of nursing actions and assist nurses in evaluating the development of the client's condition and determining the next steps to care. This standard aims to ensure that nursing care services are carried out safely, effectively, quality, and in accordance with the principles of professional ethics. With SLKI, the success of nursing care can be evaluated objectively, measurably, and in accordance with the client's needs (Suraharta, 2024).

The following are the main output standards of delusion with objectives and outcome criteria:

Table 2.1 Delusion Nursing Output Standards

Orientation Status					**L.09090**
Definition **Belief that appropriate to reality**					
Expetasi			**Improved**		
Results Kriteria					
	Loward	**Low-Moderate**	**Moderate**	**Simply Increase**	**Increase**
Productivity	1	2	3	4	5

In table 2.1**,** The higher the score the patient obtains, the better the patient's onboarding status**,** which indicates an improvement in reality orientation ability. Conversely, the lower the score indicates a higher reality orientation disorder**.**

Table 2.2 Delusion Nursing Output Standards

	Increase	Symply Increase	Moderate	Low-Moderate	Loward
Delusion Verbalization	1	2	3	4	5
Delusion Behavior	1	2	3	4	5
Worried	1	2	3	4	5
Suspicion	1	2	3	4	5
Hostility	1	2	3	4	5
Anxiety	1	2	3	4	5
Withdrawal	1	2	3	4	5

In Table 2.2, the higher the score, the lower the level of patient orientation status. This shows that the manifestations of disorders, such as verbalization of behavior, behavior, worry, suspicion, hostility, tension, and withdrawn behavior, are decreasing. Conversely, the lower the score obtained, the higher the level of onboarding status experienced.

Table 2.3 Delusion Nursing Output Standards

	Deteriorating	Getting Worse Enough	Medium	Quite Improved	Improve
Behavior according to reality	1	2	3	4	5
Fill in according to reality	1	2	3	4	5
Talk	1	2	3	4	5
Concentration	1	2	3	4	5
Sleep patterns	1	2	3	4	5
Decision-making ability	1	2	3	4	5
Thought Process	1	2	3	4	5
Self-Care	1	2	3	4	5

In Table 2.3, the higher the score the patient obtains, the better the patient's reality-oriented status, which is characterized by behavior and thought content that is in accordance with reality, directed talk, good concentration, improved sleep patterns, improved decision-making ability, logical thought processes, and better self-care. Conversely, the lower the score obtained, the worse the patient's reality orientation status, which indicates that the reality orientation disorder is still high and the symptoms experienced by the patient are still prominent.

2.5.4 Nursing Intervention

According to the Indonesian Nursing Intervention Standard (SIKI), SIKI is a guideline used by nurses in developing and implementing nursing interventions to provide safe, effective, and in accordance with applicable professional standards and regulations. SIKI is one of the important components in nursing practice because it serves as a reference in determining the right course of action based on the client's diagnosis and needs. Nursing intervention is all actions or therapies carried out by nurses based on science, skills, and clinical considerations to improve health status, prevent health problems, and assist the client's recovery process, both at the individual, family, and community levels.

The implementation of nursing interventions in various health care facilities in Indonesia has basically referred to various international standards and references. However, before there was a standard standardization, the use of terminology and the implementation of nursing interventions still varied between institutions. Therefore, the use of standardized terminology is indispensable to improve the accuracy, efficiency, and effectiveness of nursing care. In an effort to realize this uniformity, the Indonesian National Nurses Association (PPNI) published the Indonesian Nursing

Intervention Standard (SIKI) as a national guideline in nursing practice (I Made Suraharta, 2024)

1. Delusion Management
2. Reality Orientation

As well as supporting interventions as follows:

1. Hallucination Management
2. Mood Management
3. Anger Control Management
4. Social Skill Behavior Modification
5. Medication Administration
6. Prevention of Delusion
7. Family Support Promotion
8. Self-Esteem Promotion
9. Self-Care Promotion
10. Promotion Support System

Here are the main intervention tables of Delusion Management:

Table 2. 4 Nursing Action Plan

Management Personality (1.09295)	Definition: Identify and manage the comfort, safety, and reality orientation of patients who experience erroneous and persistent beliefs that are little or nothing based on reality.
Observations	1. Monitor the content of which endangers oneself, others and the environment 2. Monitor the therapeutic effects and side effects of the drug
Terapeutik	3. Build interpersonal relationships of mutual trust 4. Demonstrate a consistent non-judgmental attitude 5. Discuss the discourse by focusing on the underlying feeling ("you look like you're feeling scared")

	6. Avoid arguing about erroneous beliefs, express doubts according to facts
	7. Avoid reinforcing the idea of delusion
	8. Provide a safe and comfortable environment
	9. Provide leisure and diversion activities as needed
	10. Conduct behavioral control interventions (e.g. limit setting, territorial restrictions, physical restraint, or exclusion)
Education	11. Encourage revealing and validating the truth (reality test) with a trusted person (caregiver/family)
	12. Encourage a consistent daily routine
	13. Practice stress management
	14. Explain about the disorder and related illnesses (e.g., delirium, schizophrenia, or depression), how to cope and medications given
Collaboration	15. Collaboration in the administration of medicines, as indicated