# Reverse Imposter Syndrome? Managing Challenging Delusions on a Behavioral Health Unit

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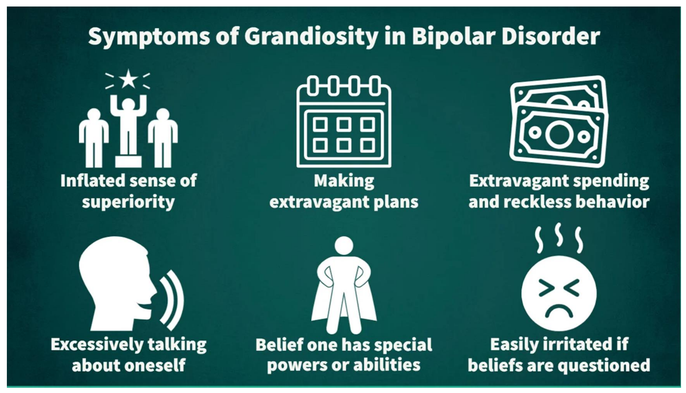
## Introduction

Imposter syndrome is well described among medical trainees as a pervasive pattern of self-doubt despite objective competence.[1] However, its conceptual inverse, overconfidence rooted in psychopathology among this population, receives far less attention in clinical training. At its extreme, such overconfidence may manifest as grandiose delusions, with the potential to disrupt both patient care and the therapeutic milieu in the inpatient setting.[2] This case examines a patient who completed multiple years of medical school and explores the assessment and treatment of grandiose delusions emphasizing clinical reasoning, therapeutic boundaries, and interdisciplinary care in an acute psychiatric setting.




## Case Description

XC is a 36-year-old female with a past psychiatric history of schizoaffective disorder, bipolar type, who had completed three years of medical school approximately six years ago. She experienced acute psychiatric decompensation in the setting of medication noncompliance and initially presented at a rural emergency department. At the time she displayed disorganized and manic behavior accompanied by delusional ideation that she was a practicing neurosurgeon. She was admitted voluntarily to an inpatient behavioral health unit for stabilization. While hospitalized, XC intermittently engaged in "rounding" behaviors, presenting herself as a physician to staff and patients. Although occasionally redirectable with reality testing, she frequently returned to her delusional identity. She was stabilized on oral olanzapine and valproic acid and discharged home where she lived with her father. XC repeatedly discontinued medications leading to her recurrent decompensation and multiple psychiatric hospitalizations over approximately six months. Her most recent hospitalization followed an assault on her father and threats of lethal violence, resulting in involuntary commitment. While inpatient, XC continued to assert that she was a practicing neurosurgeon and maintained business casual dress and grooming standards. She introduced herself as a physician and completed her own intake interview with a different patient. XC attempted to elope by convincing a covering psychiatrist that she was also a healthcare professional who forgot their badge. Due to these persistent behaviors, staff education was provided during daily treatment teams to better limit XC's opportunities to inappropriately interact with other patients and prevent elopement. She was stabilized on haloperidol 10 mg twice daily and was discharged with outpatient psychiatric follow up.  XC presented most recently to the hospital with similar course of discontinuing medications. At that time treatment team felt patient required more supportive treatment with Extended Acute Care. She was continued on Haldol and mood stabilizer Trileptal was added. As patient progressed through hospitalization, reality testing improved but depressive symptoms emerged. Patient was started on Fluoxetine for depressive symptoms and one on one therapy was provided to assist patient with facing reality and disentangling from chronic delusions.

## Discussion

This case illustrates the complexity of managing grandiose delusions in patients with prior medical training, where professional identity and psychopathology may become tightly intertwined. Familiarity with medical language and systems can lend apparent credibility to delusional beliefs, complicating assessment, and increasing the risk of boundary violations. Effective inpatient management requires consistent interdisciplinary communication, firm but empathic boundary setting, and avoidance of collusion with delusional content. Pharmacologic treatment should target the underlying diagnosis, with psychotherapy focusing on insight, identity reconstruction, and adaptive coping as grandiosity diminishes. Conceptualizing these presentations as "reverse imposter syndrome" may help clinicians frame grandiosity as a maladaptive response to vulnerability or threatened professional identity.

## Conclusion

This case highlights the importance of recognizing and systematically managing grandiose delusions in medically trained patients, where professional identity can amplify psychopathology and necessitates structured, empathic, and interdisciplinary approaches to care.

## References

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