

# EKBOM SYNDROME (DELUSIONAL PARASITOSIS): A 9 YEAR LONG CASE REPORT

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## SUMMARY

**Background:** Delusional Parasitosis (DP), or Ekbom Syndrome, is a rare psychodermatological condition marked by a fixed false belief of infestation with parasites despite the absence of objective evidence. Patients often resist psychiatric referral and frequently disengage from mental health services. Complex identity factors, including professional roles, may complicate insight and treatment engagement. This report presents a longitudinal case of a female psychotherapist with DP who remained engaged with psychiatric services for nine years, offering an opportunity to explore the ethical and therapeutic implications of professional identity in the context of psychosis.

**Subjects and methods:** A retrospective case analysis of a 58-year-old psychotherapist with DP, incorporating clinical observations, interdisciplinary input, and critical review of current literature.

**Results:** The patient exhibited classic DP features and underwent multiple antipsychotic trials, with varying adherence and outcomes. Her status as a mental health professional presented unique challenges, including denial of psychiatric pathology, ethical conflicts, and difficulty establishing a therapeutic alliance. Despite persistent delusional conviction, a longitudinal therapeutic relationship was maintained through multidisciplinary strategies and adapted communication. Clozapine was considered but not initiated.

**Conclusions:** This case illustrates that sustained psychiatric engagement is possible even in treatment-resistant DP and emphasizes the need for individualized care, especially when professional identity intersects with psychosis. The case contributes to emerging perspectives on interdisciplinary management and therapeutic alliance in chronic psychodermatological conditions.

**Key words:** Delusional Parasitosis - Ekbom Syndrome – psychodermatology – clozapine - mental health professional

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## INTRODUCTION

Delusional parasitosis (DP), also referred to as Ekbom Syndrome, is characterized by a persistent false belief of being infested with parasites, in the absence of objective medical evidence. It predominantly affects middle-aged or elderly females (Freudenmann & Leping 2009). Patients typically seek help from dermatologists or general physicians, often resisting psychiatric explanations. Recent literature underscores a need for integrated psychodermatology clinics to enhance adherence (Pathmarajah et al. 2025).

## SUBJECT AND METHODS

J.K., a 58-year-old woman, was first referred in 2016 after multiple emergency visits for perceived parasitic infestation. She described abnormal sensations across her abdomen and limbs and repeatedly requested invasive investigations despite normal findings. A retrospective review of her clinical records and most recent literature was performed to contextualize the course of her condition.

## RESULTS

J.K. had a long-standing history of somatic preoccupations, including hypothyroidism and IBS. Despite

repeated negative tests, she remained convinced of an infestation. Over the years, she was trialed on Pimozide, Olanzapine, Risperidone, Amisulpride, and Aripiprazole, with partial compliance.

She displayed classical features of DP and persistent somatic delusions. Her episodes of remission were interspersed with relapses, often triggered by psychosocial stressors. Remarkably, she remained engaged with psychiatric services throughout - a rare outcome for DP patients, as discontinuation is more common (Ruiz Santos & González González 2025).

Additional context from collateral history and MDT evaluations highlighted J.K.'s progressive decline in functional capacity. She exhibited increasing social withdrawal, disrupted sleep, and nutritional neglect during acute exacerbations. Insight remained poor throughout, although some therapeutic alliance was achieved via repeated psychoeducation and validation techniques. Her behavior was notable for the 'matchbox sign' - presentation of lint or skin flakes as 'specimens' - and repeated use of over-the-counter antiseptics on excoriated skin. The patient was periodically reviewed by dermatology and infectious disease teams, who confirmed absence of parasitic infestation, though the patient disputed their conclusions. Despite frequent relapses, the patient showed moments of improved hygiene, reduced preoccupations, and increased social interaction under stable

pharmacological regimens, suggesting partial responsiveness.

The sustained nine-year engagement described here offers rare insight into the longitudinal management of DP. Interdisciplinary collaboration - including dermatology, general medicine, psychiatry, and community mental health - proved essential. This case also illustrates the utility of non-confrontational strategies and repeated, empathetic clarification of test results to build trust. Education for both patient and family helped reduce reinforcement of delusional beliefs. Moreover, pharmacy-based intervention was revised to standardize messaging, consistent with recommendations by Pathmarajah et al. (2025).

Further examination of the case reveals the paradoxical complexity of J.K.'s psychiatric presentation. A qualified psychotherapist herself, J.K. held a private practice prior to the onset of her symptoms, which adds an unusual dimension to the evolution and management of her illness. Her professional background initially contributed to a convincing façade of wellness, delaying the recognition of psychopathology by several clinicians. Colleagues and family members reported a subtle erosion in her clinical reasoning and interpersonal sensitivity, manifesting as increased rigidity and suspiciousness in interactions. J.K. continued to conduct therapy sessions in the early phases of her illness, during which she reportedly alluded to her own 'research' into underdiagnosed parasitic infections, even directing clients to undergo unnecessary dermatological testing. Ethical concerns eventually prompted intervention by her professional association, resulting in a temporary suspension of her license.

This aspect of the case introduces a unique ethical and identity-related conflict. As a mental health practitioner developing a fixed somatic delusion, J.K. experienced considerable shame and defensiveness, often framing her interactions with the psychiatric team as 'academic discussions' rather than therapeutic consultations. This dynamic complicated rapport-building and necessitated a non-hierarchical, collaborative approach that respected her intellectual capabilities while gently challenging delusional content. Clinicians found success with motivational interviewing and metacognitive strategies, helping J.K. to reflect - at least partially - on inconsistencies in her reasoning without direct confrontation.

Functionally, J.K.'s decline was marked by a progressive reduction in her capacity to maintain professional relationships, personal hygiene, and self-care routines. Despite persistent conviction in her delusional beliefs, she retained an interest in medical literature and frequently engaged with online forums, further reinforcing her preoccupations. The psychiatric team had to contend with information overload and health misinformation, particularly from pseudoscientific websites advocating for unvalidated treatments.

This underscores the importance of digital literacy as a component of psychoeducation in modern psychiatric care.

Psychotherapeutic efforts were directed toward distress reduction and improving daily functioning rather than direct delusional confrontation. Techniques such as distress tolerance training, behavioral activation, and limited exposure to social contexts were integrated into care. Despite numerous setbacks, the care team maintained a longitudinal alliance by adapting communication style, maintaining predictable follow-up intervals, and ensuring that care decisions involved the patient collaboratively - even when psychotic content predominated discussions.

J.K.'s trajectory underscores the importance of clinician adaptability and underscores how professional identity may complicate psychiatric insight. Her dual role as both a practitioner and patient created a complex countertransference in the treating team, requiring reflective practice and clinical supervision to maintain therapeutic neutrality and avoid minimization of risk due to professional status. The intersection of professional self-concept, psychosis, and long-term psychiatric engagement in this case provides fertile ground for future qualitative exploration in both forensic and clinical settings.

The role of integrated care, including psychological support and education about medication, proved essential. As highlighted in the study by Pathmarajah et al. (2025), discrepancies in counselling between clinicians and pharmacists may impair adherence. In this case, coordinated psychoeducation improved therapeutic relationships and insight.

## DISCUSSION

Delusional parasitosis is classically considered a monosymptomatic hypochondriacal psychosis and often proves challenging for mental health professionals. Patients frequently present to dermatologists or general physicians rather than psychiatrists, and many disengage from psychiatric care early in the course (Freudenmann et al. 2009; Wilson & Uslan, 2004). The chronicity and complexity observed in this case contradict these trends and support growing literature calling for sustained, multidisciplinary management (Torales et al. 2020; Brownstone et al. 2022).

Patients may exhibit compulsive behaviors such as over-washing or self-inflicted skin trauma due to the severity of their delusional experiences (Waykar et al. 2021). The concept of psychodermatoses as a diagnostic spectrum, highlighted by Novosartyan and Hovhannisyan (2025), situates DP within a broader clinical context involving somatic and cognitive overlap. This is echoed by Ruiz Santos and González González (2025), who documented cases of shared

psychotic disorder (folie à deux) in DP, illustrating familial transmission of fixed beliefs.

Antipsychotic medication remains the mainstay of treatment. Pimozide, risperidone, olanzapine, and aripiprazole have all been used with varying efficacy, as in this case. Meehan et al. (2006) report successful outcomes with olanzapine, while Lepping et al. (2007) recommend risperidone as first-line therapy. However, non-adherence remains a major issue, particularly when patients do not perceive their symptoms as psychiatric. In this regard, recent studies underscore the impact of uncoordinated messaging between health-care providers, especially pharmacists (Pathmarajah et al. 2025).

While delusional parasitosis is commonly managed with first- and second-generation antipsychotics, treatment resistance is frequently encountered, particularly in chronic or comorbid psychotic conditions. In such cases, clozapine may be considered.

Recent case reports have shown that clozapine, often regarded as a treatment of last resort in schizophrenia, can be effective in managing refractory DP. Singh et al. (2022) presented a case where clozapine, in combination with electroconvulsive therapy (ECT), led to significant improvement in delusional symptoms when other antipsychotics failed.

Although not used in the current case due to partial response and adherence limitations, clozapine should be considered in future treatment protocols for chronic DP, especially when insight remains limited despite comprehensive intervention.

Environmental triggers may also play a role in precipitating or perpetuating DP. Hahn et al. (2025) describe a case where real bedbug exposure catalyzed delusional infestation in a vulnerable patient, emphasizing the importance of psychosocial context. Our patient's relapses frequently coincided with psychosocial destabilization, further affirming the role of comprehensive psychosocial support.

## CONCLUSIONS

This case illustrates that sustained psychiatric engagement in DP is not only possible but beneficial. It challenges prevailing assumptions regarding delusional parasitosis as an untreatable or disengaged condition and emphasizes the importance of a compassionate, consistent, and collaborative care model. Indeed, long-term psychiatric engagement, individualized pharmacological strategies, and multidisciplinary coordination can yield meaningful clinical improvements, even in chronic, treatment-resistant presentations. While Clozapine remains underutilized, emerging evidence supports its consideration in selected DP cases with persistent symptoms. As psychodermatology advances, multidisciplinary strategies should be explored to enhance engagement and treatment

adherence. Future research should focus on optimizing integrated care pathways and developing evidence-based protocols to manage this complex, under-recognized disorder effectively.

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Anne-Frederique Naviaux: concept and design of article, literature searches, writing manuscript, approval of final version.

Regina Saku: patient case report summary and presentation, approval of final version.

All authors approved the final manuscript.

## References

1. Absy N, Saleh N & Al Sharman D: Ekbom syndrome: a case report. *BJPsych Open* 2022; 8(S1):S117. doi:10.1192/bjo.2022.350
2. Brownstone N, Howard J & Koo J: Management of delusions of parasitosis: an interview with experts in psychodermatology. *Int J Womens Dermatol* 2022; 8:e035. doi:10.1097/JW9.000000000000035
3. Di Lu J, Gotesman R, Varghese S, Fleming P & Lynde CW: Treatments for primary delusional infestation: systematic review. *JMIR Dermatol* 2022; 5:e34323
4. Freudenmann RW & Lepping P: Delusional infestation. *Clin Microbiol Rev* 2009; 22:690–732
5. Hahn D, Miller D, Fung J, Mo H, Lind S: Bugs bugging the body and the brain: a case of a bed bug infestation progressing to delusions of parasitosis treated with clozapine. *Cureus* 2025; 17:e80110. doi:10.7759/cureus.80110
6. Haq BU, Zaidi KI, Nikookam Y, Irfan M & Khan S: An in-depth critical analysis of Morgellons: delusion or disease? *J Clin Basic Psychosom* 2025; X(X):1–13. doi:10.36922/jcbp.4735
7. Keenan K & Clarke C: Ekbom Syndrome – A case report. *Eur Psychiatry* 2023; 64(S1):S1063–S1064. doi:10.1192/j.eurpsy.2023.2257
8. Lepping P, Russell I, Freudenmann RW: Antipsychotic treatment of primary delusional parasitosis: systematic review. *Br J Psychiatry* 2007; 191:198–205
9. Lepping P, Huber M & Freudenmann RW: How to approach delusional infestation. *BMJ* 2015; 350:h1328
10. Meehan WJ, Badreshia S & Mackley CL: Successful treatment of delusions of parasitosis with olanzapine. *Arch Dermatol* 2006; 142:352–355
11. Mindru FM, Radu AF, Bumbu AG, Radu A & Bungau SG: Insights into the medical evaluation of Ekbom syndrome: an overview. *Int J Mol Sci* 2024; 25:2151
12. Novosartyan M & Hovhannisyanyan H: Psychodermatoses: diagnostic and therapeutic challenges. *J Dermatol Res* 2025; 6:1–10. doi:10.46889/JDR.2025.6102
13. Pathmarajah P, Gkini MA, Taylor RE: Patients with delusional infestation are being given conflicting advice by pharmacy colleagues. *Br J Dermatol* 2025; 192:550–551. doi:10.1093/bjd/ljae411

14. Ruiz Santos MA, González González C: Parasitosis delirante y folie à deux: reporte de psicosis compartida en paciente con deterioro cognitivo vascular. *Rev Fac Med UNAM* 2025; 68:26–31.  
doi:10.22201/fm.24484865e.2025.68.2.03
15. Singh A, Shah R, Cholera R, Mulky P: Treatment of Ekbom Syndrome with Clozapine and Electroconvulsive Therapy. *Cureus* 2022; 14:e30469.  
doi:10.7759/cureus.30469
16. Skelton M, Khokhar WA & Thacker SP: Treatments for delusional disorder. *Cochrane Database Syst Rev* 2015; Issue 5:CD009785.  
doi:10.1002/14651858.CD009785.pub2.
17. Torales J, García O, Barrios I, O'Higgins M, Castaldelli-Maia JM, Ventriglio A & Jafferany M: Delusional infestation: clinical presentations, diagnosis, and management. *J Cosmet Dermatol* 2020; 19:3183–3188
18. Waykar V, Wourms K, Tang M & Joseph V: Delusional infestation: an interface with psychiatry. *BJPsych Adv* 2021; 27:343–348
19. Wilson FC & Uslan DZ: Delusional parasitosis. *Mayo Clin Proc* 2004; 79:1470
20. Yaprak F, Temirkaynak MK, Ertek IE, Lepping P & Coşar B: Delusional infestation: Folie à famille - a rare case. *Acta Derm Venereol* 2025; 105:adv42186.  
doi:10.2340/actadv.v105.42186
21. Zomer SF, de Wit RFE, van Bronswijk JE, Nabarro G & van Vloten WA: Delusions of parasitosis: a psychiatric disorder to be treated by dermatologists? *Br J Dermatol* 1998; 138:1030–1032

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