Seeing Eye to Eye: Building Trust in Delusional Disorder

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Background and Objective

Background: Delusional infestation (DI), also known as delusional parasitosis, is a fixed false belief which persists against all medical evidence that one's skin, body, or both are infested by small, vivid pathogens[1]. Poorly understood pathophysiology along with insight deficits commonly found in patients with DI render it difficult to treat[2].

Objectives: We present the case of a patient with DI, along with multiple concurrent difficult to treat disorders, to highlight treatment challenges in the setting of a tenuous doctor-patient relationship.

Case Summary

43-year-old male with a past medical history of Hepatitis C and psychiatric diagnoses of antisocial personality disorder, alcohol use disorder and sedative hypnotic use disorder presented to the emergency room with pre-septal cellulitis of his right eye after attempting to use bleach to exterminate a "worm" infestation.

He was admitted to the medicine service for IV antibiotic treatment and psychiatric consultation was requested given suspicion for DI. Upon exam, the patient described a complex network of delusions regarding the infestation of worms in his skin, GI tract, bloodstream, and eyes that was not medically validated; this belief was aggressively recalcitrant to counterargument. He also described a prior interspersed 20-year incarceration history from multiple instances of assault, robbery and theft. In the past year, he had seen numerous doctors spanning multiple specialties, and had been involuntarily committed to psychiatric wards three times. Prior to current hospitalization, he was self-medicating with 1-2 gallons of boxed wine daily, along with large quantities of gabapentin (4-6 grams) and street bought benzodiazepines to "stay calm."

Discussion

Multiple factors complicated the approach to treatment in this case. Most apparent among them was a loss of trust for physicians, particularly psychiatrists, whose involvement the patient equivocated to being "written off." Additionally, underlying personality traits exacerbated tensions between the patient and treatment team, as frequent verbal threats and posturing were used in attempts to alter treatment course. To build trust, our team focused on the distress the patient was experiencing from his current condition, offering olanzapine to reduce intrusive thoughts.

For disposition, we did not pursue another involuntary commitment for psychiatric treatment, as three prior commitments had not shown efficacy. We determined close outpatient follow up to be more suitable, as it correlated with patient preference and affirmed his sense of autonomy. Ultimately, the patient refused to pursue treatment for substance use disorder. This case highlights how a patient was utilizing various maladaptive behavioral patterns from comorbid psychiatric conditions to reduce distress associated with DI. By focusing on the distress, we were able to reduce his distrust, and agree on a way forward.

Conclusion

In difficult to treat psychiatric disorders, like DI, focusing on the patient's goals may offer common ground from where psychiatric treatment can be ensued.

References

1). Freudenmann, R. W., & Lepping, P. (2009). Delusional infestation. *Clinical microbiology reviews*, *22*(4), 690–732.

2). Lai, J., Xu, Z., Xu, Y., & Hu, S. (2018). Reframing delusional infestation: perspectives on unresolved puzzles. *Psychology research and behavior management*, *11*, 425–432.