I. Morán Sánchez[1]
A. de Concepción Salesa[2]

Chronic hallucinatory psychosis. A case report

[1]Centro de Salud Mental
Cartagena (Murcia)

[2]Hospital Psiquiátrico Román
Alberca (Murcia)

Chronic hallucinatory psychosis is a clinical picture described by Ballet in 1912. Together with paraphrenia and paranoia, it forms a part of the chronic delusions that describes the French nosology separately from schizophrenia. It is characterized by the presence of mental automatism, chronic hallucinations and secondary delusions. This is a fairly uncommon clinical picture in our setting and is often confused with other pictures. We report a case of a 52-year-old woman and we discuss various clinical and diagnostic issues related to the disturbance.

Key words:
Chronic hallucinatory psychosis, diagnosis, involuntary treatment

Actas Esp Psiquiatr 2010;38(6):372-3

Psicosis alucinatoria crónica. A propósito de un caso

La psicosis alucinatoria crónica es un cuadro clínico descrito por Ballet en 1912. Junto con la parafrenia y paranoia forma parte de los delirios crónicos que describe la nosología francesa de forma separada de la esquizofrenia. Constituye un cuadro clínico con automatismo mental, alucinaciones crónicas y delirios secundarios a dichas alucinaciones. Es una entidad poco frecuente en nuestro medio y que a menudo se confunde con otros cuadros clínicos. Presentamos el caso clínico de una mujer de 52 años y consideramos varios aspectos clínicos y diagnósticos relacionados con la alteración

Palabras clave:
Psicosis alucinatoria crónica; diagnóstico diferencial, tratamiento involuntario

Correspondence:
Inés Morán Sánchez
CSM Cartagena.
Calle Real nº 8.
CP 30201. Cartagena (Murcia)
E-mail: Inmosa77@hotmail.com

INTRODUCTION

Chronic hallucinatory psychosis is a clinical picture first described by G. Ballet.[1] It is characterized by the presence of mental automatism, together with hallucinations and delusions.[2] Although the patients do not have schizophrenia-type defect, the prognosis is not totally favorable since the symptoms do not completely disappear with psychodrugs.[3] In recent years, cognitive-behavior type therapies are being tested to improve the diagnosis.[4]

CLINICAL CASE

We present the case of a 52-year old woman who was referred from primary care for evaluation of probable psychotic symptoms.

She had no somatic background of interest. The EEG and cranial CT scan were normal. As psychiatric background, she had a hospital admission with diagnosis on discharge of disorder due to delusional ideas. She did not follow treatment and did not go to psychiatric checkups after on her own initiative. She returned to the Mental Care Center for evaluation when she requested discharge in order to return to work.

The clinical picture began approximately two years before she came to our medical office. At work, she began to hear voices that reproached her. She interpreted these voices as revenge from a colleague who was in love with her. As he was not reciprocated, he began to insult her in order to make her leave her workplace. She believed that the voices could reach her through her computer or by telephone so that she disconnected both of them. At home, she began to hear the voices and interpreted them as part of a complot. She had null awareness of disease and need for treatment, so that after her first contact with Mental Health, she decided not to return for the check-ups. Therefore, she was referred to the hospital for admission. After hospital discharge, she continued without follow-up and when she

came to our medical office, the symptoms had not varied, although the idea of a complot to keep her away from work had become stronger. We also found thought diffusion and telepathy phenomena, which the patient interpreted as secondary to the medication prescribed, "that she has been channeled towards a parallel world." She was well-dressed, with good appearance. Her speech was long-winded with pronounced stress when referring to the work subject. Suspicious with null disease awareness. No hostile or disruptive behaviors appeared secondary to the delusional-hallucinatory picture, although the usual tendency to isolation of the patient was even greater (this was confirmed in interviews made with family members). No biological rhythm disorders were observed.

DISCUSSION

The interest of this clinical case is because of the diagnostic and therapeutic difficulties. We propose the possible diagnoses of schizophrenia, temporal lobe epilepsy, delusional ideas disorder and chronic hallucinatory psychosis. The absence of formal thought and process deterioration disorders had led us to rule out schizophrenia.[5] The normal EEG and absence of other characteristics of seizures go against the diagnosis of temporal epilepsy. The fact that the hallucinatory picture was primary with a subsequent delusional development and the persistence of hallucinations during the entire process had led us to rule out delusional idea disorder and to issue the final clinical opinion of Chronic Hallucinatory Psychosis.

The therapeutic approach is difficult because of the total lack of disease awareness, pronounced suspicion of the patient and previous unsatisfactory experiences. We tried to establish a therapeutic alliance during frequent interviews, stressing the need for treatment of objective features such as anxiety and the effective repercussion on everything she told us.[6] In the interviews, we avoided direct confrontation of the delusions and excessive kindness to avoid increasing her suspiciousness. We began antipsychotic treatment with slow dose increases to minimize side effects and we made an agreement with her to evaluate response and successive visits. After obtaining the patient's permission, we contacted her family members and the medical practitioner. We assured with the family that there were no severe alterations at home. We established common action regimes with the medical practitioner. If minimum behavioral alteration or self- or hetero-aggressive ideas appear, we will proceed to hospitalization.

After several failed drug attempts (incongruent side effects with the doses prescribed were reported) we proposed depot antipsychotic medication, the patient totally rejecting this possibility. Her motivation for treatment, as she openly expressed, was to obtain a psychiatric report allowing her to return to work. After achieving it, she stopped coming to the check-ups. We proposed including her in the assertive community treatment program, with unsuccessful results.

At this point, in which the conventional therapeutic relationship has ended, we are proposing the possibility of forced outpatient treatment.[7] Although there is no specific legislation in this field that makes it possible to have a standardized application, in our country, there are isolated experiences with good preliminary results. Its application is not exempt of controversy, its detractors considering it a repressive measure that increases stigmatization. However, in patients diagnosed with psychosis and together with the intensive follow-up programs in the community, the risk-benefit balance would be positive. We consider that our patient would benefit from this type of treatment.

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