10 - Hallucinations

Hallucinations

© SPMM Course They are intermediate between fantasy (imagery) and hallucinations. Like fantasy they are in subjective space, lack quality of concrete reality, have quality of idea and so not sought in other modalities simultaneously (not searched for, no attempts to reach out etc.) and appreciated to be observer-dependent, self-originating. Like a hallucination, they have a clear outline, vivid, retained for the good length of time, cannot be dismissed at will and are behaviourally and emotionally relevant i.e. acted upon or felt for. The hallucinatory experiences of bereavement and in Ganser's state are pseudohallucinations

Hallucinations Hallucinations have several important qualities that are essential in differentiating from other mental phenomena:

1. They take place at the same time as other sensory perceptions – e.g. the voice is heard even when music is playing, or someone is talking to me. So they are different from dreams where no real component exists alongside the false perception.
2. They take place in the same space as other perceptions - angel is seen standing at the corner of my room. This is different from fantasy or imagery which takes place in subjective space.
3. They are experienced as sensations – not as thoughts – contrast from obsessional images.
4. The percept has all qualities of an object – i.e. it is believed that it can be experienced in other modalities too, like a real object which can be seen, felt, smelt and heard. This is why hallucinators search for the man behind the voice or try and reach out and touch visual percepts.
5. They are involuntary – appearance cannot be controlled; independent – will exist even when not perceived by the hallucinators; may lack the quality of publicness – not every one could hear and see them. Auditory Hallucinations: Elementary, unstructured hallucinations are seen in acute organic states. Musical hallucinations are similar to Charles Bonnet syndrome in visual domain – can occur in those with deafness, also in organic conditions. Formed auditions like voices – as in thought echo – cannot be elementary. Phonemes are any auditory hallucinations that occur as human voices. Schizophrenic phonemes are usually multiple, may or may not be recognizable, usually male with a different accent, speaking in one's mother tongue and usually episodic - almost never continuous. When a same word is repeated continuously, normal subjects hear phonetically linked but different words. Hallucinating schizophrenia TRUE HALLUCINATION PSEUDO HALLUCINATION Objective, outside spatial location Absence of insight Sought in other modalities (see text) Often seen in psychosis Subjective spatial

location The presence of insight, often. Not sought in other modalities usually. Often in personality disorders, following trauma, dissociative experiences.

© SPMM Course subjects hear different words that have no phonetic connection to the original repeated word – this is called verbal transformation effect. Patients could be distracted away from their voices, but it is the attention paid to the external stimulus which is more important than the degree of external stimulus used to distract. Alcoholic hallucinosis initially starts as fragmented voices, later organised into clear voices. Visual hallucinations: Occipital lobe tumours, postconcussional states, epileptic twilight state, hepatic failure (any toxic delirium), dementia are some causes for visual hallucinations. 30% of old age psychiatric referrals have visual hallucinations. Solvent sniffing and hallucinogens can cause elementary visual hallucinations like light flashes. Simultaneous visual-verbal hallucinations – green man speaking to me – is seen in TLE. Visual hallucinations are very uncommon in schizophrenia (But Andreasen quotes 30% in a series observed with acute schizophrenia). Reports of “black patch” psychosis were frequent following simultaneous bilateral cataract surgery in the early era of the procedure, attributed to sensory deprivation, leading to the recommendation that only one eye be operated on at a time. It was subsequently recognized that “black patch” psychosis was a relatively uncommon postoperative delirium partly due to anticholinergic eye drops.* Charles Bonnet Syndrome: Elderly patients, with normal consciousness and no brain pathology, with reduced visual acuity due to ocular problems, experience vivid, distinct, usually well-coloured (in contrast to real sensation that is blurred due to eye disease) formed hallucinations – mostly humans, at times animals and cartoons. These objects usually show movement, and can be voluntarily controlled – disappear on closing the eyes; insight about unreality is usually preserved – though they may evoke emotions including fear and joy. About 1/3rd are elementary; usually the hallucinations are located in external space. Podoll's criteria for diagnosis include: Elderly person with normal consciousness with visual hallucinations; not in the presence of delirium, dementia, psychosis, intoxication or neurological disorder with lesions of central visual cortex; reduced vision resulting from eye disease (most commonly macular degeneration). The syndrome can occur in people with normal vision1,2 Lilliputian hallucinations can occur in visual or haptic mode – they usually involve seeing tiny people or animals (or feeling diminutive insects crawling if haptic) and are seen in delirium tremens and unlike other organic visual hallucinations, Lilliputian hallucinations can be accompanied by pleasure though often intermingled with terror. These are not the same as micropsia. Patients with DT often have a prodromal affect or pareidolic illusions before these hallucinations. Autoscopic hallucinations are the visual experience of seeing oneself. Males predominate 2:1, impaired consciousness is a common accompaniment and depression is the commonest psychiatric cause. They are also called phantom mirror images and may take the form of pseudohallucinations. Schizophrenia (usually pseudo), TLE, parietal lesions (organic states more likely to have true hallucinations) are also implicated. In negative autoscopy, one looks into a mirror and sees no image at all. Palinopsia: palin for "again" and opsia for "seeing". It is a visual disturbance that causes images to persist even after their corresponding stimulus has left. It is seen in LSD use, migraine, occipital epilepsy, head trauma. It is similar to afterimage, but colour inversion (usually shadows or distorted colours noted in afterimages) is conspicuously absent.

© SPMM Course Somatic hallucinations: These can be divided into superficial, visceral and kinaesthetic. The superficial somatic hallucinations are tactile (haptic - touch), hygric (fluid – wetness etc.) and thermic (heat or cold). Visceral hallucinations are usually pain-like sensations arising from deep viscera like liver. These are sometimes termed as coenesthetic hallucinations

and suggest schizophrenia. Kinaesthetic or proprioceptive hallucinations refer to joint or muscle sense, often linked to bizarre somatic delusions. They are also seen in benzodiazepine withdrawal and alcohol intoxication. Formication (formic acid – from ant) is a special type of haptic hallucination – unpleasant sensation of little animals or insects crawling under the skin, seen in DT and cocaine intoxication. Tactile hallucinations can be seen in parietal seizures. Superficial somatic hallucinations are almost never noted in TLE though the visceral sense of ‘raising epigastrium’ is seen. The common experience of the phantom limb is a body image disturbance and not a hallucination; though it is in external space, it does not satisfy other qualities of hallucination and patients are aware of unreality usually. It is a body image disturbance with a neurological basis. Somatic hallucinations may or may not be accompanied by passivity delusions. Without the passivity delusions, they cannot be classed as a First rank symptom. Olfactory hallucinations can occur in the aura of TLE – usually burning smell or urine smell. In depression, this can be an adjunct to nihilism. Gustatory hallucinations e.g., bitter taste of poison can give rise to delusions of persecution in schizophrenia. They are also seen in TLE. Extracampine hallucinations: Hallucinations that occur outside the normal field of perception e.g., images seen behind your back, under your sternum or hearing voices from Inverness, etc. They occur in schizophrenia, epilepsy and also in hypnagogic hallucinations of healthy people – so not diagnostically important. Both illusions and hallucinations are not necessarily pathological though they both are false perceptions, along with pseudohallucinations. For example hypnagogic hallucinations (hallucinations when going to sleep – go for gogic - usually auditory. Also seen in Narcolepsy-cataplexy. They can be visual or tactile too. First noted by Aristotle) and hypnopompic hallucinations (hallucinations when waking up) can occur in normal individuals. Hallucinations also occur in glue sniffing, post-infective depression, children with fevers and in phobic anxiety. Sensory deprivation in normal healthy people can also produce hallucinations. They are not more frequent in schizophrenia than other conditions. Functional hallucinations: An external stimulus provokes hallucination, and both hallucination and stimulus are in same modality but individually perceived. e.g. voices heard whenever the noise of water running through the tap is heard. They are not illusions – as the stimulus is perceived appropriately (noise of water), but, in addition, there is another perception (voices) without any appropriate object. HYPNAGOGIC HALLUCINATIONS 3 times more common than hypnopompic 37% normal adults experience at least once Hypnopompic is more specific for narcolepsy EEG shows alpha rhythm (subject not awake) Hearing one’s name called is the most common

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