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Case report

Obsessive (pseudo)hallucinations: a diagnostic dilemma and a visit to descriptive psychopathology

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SUMMARY

Background

Obsessive-compulsive symptoms are seen in psychotic disorders, and symptoms of psychosis, like hallucinations and delusions, might occur in Obsessive-compulsive Disorder (OCD). Astonishingly, hallucinations that did not respond to conventional treatment of psychosis in a patient prompted us to investigate further and elaborate on the psychopathology. We encountered a rare finding where the hallucinations had an obsessional quality in a background of preserved functionality and cognition.

Case Summary

We present a case of a young man who started hearing unusual voices in clear consciousness, was unable to distract himself, and was distressed by the content of the same. Despite being on treatment (with adequate dose and duration of antipsychotics), he did not find relief, although he kept developing side effects. Descriptive psychopathology (with detailed and repeated mental status examinations) exposed an obsessive component to the voices ("obsessive hallucinations", a rare entity). It prompted us to reconsider the diagnosis of OCD and treatment with an antiobessive agent, to which the patient responded well.

Conclusion

A thorough elaboration of psychopathology in diagnostically challenging cases remains the gold standard of psychological investigation. Although the debate about the terminology of "pseudohallucinations" is ongoing regarding its validity and utility, cases such as this reignite the curiosity about where and how to place such entities in descriptive psychopathology.

Key words: obsessive hallucinations, descriptive psychopathology, pseudohallucinations, hallucinations

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Introduction

The modern classificatory system categorizes schizophrenia (SCZ) and obsessive-compulsive disorder (OCD) as distinct diagnostic entities. The typical features of SCZ encompass delusions, hallucinations, disorganization, and extremes of behavior, while OCD is characterized by obsessions, ritualistic behaviors, and mental phenomena (with or without insight). Despite the non-overlapping diagnostic criteria, a complex psychopathological overlap exists between SCZ and OCD. While there is an expanding body of research focusing on individuals with OCD who lack insight into their symptoms, it is noteworthy that patients with OCD can also exhibit perceptual disturbances, which are commonly associated with psychotic disorders [1,2]. These symptoms encompass hallucinations and related phenomena, varying in their degree of insight and potentially manifesting across sensory modalities such as auditory, visual, tactile, olfactory, and kinesthetic.

Hallucinations are generally considered a diagnostic marker for psycho-

sis. Even historically, the presence of ***hallucinations*** reported as ***voices***-namely, Auditory Verbal Hallucinations (AVHs), has been regarded as particularly relevant to establishing a diagnosis of schizophrenia [3-7], hallucinations in a person with reasonably preserved insight, functionality, and cognition would prompt an inquiry into either the phenomenology or the diagnosis. However, contrary to this common conceptualization of diagnostic categorization (based on psychopathology), an overlap exists even in such seemingly discrete categories of SCZ and OCD. To better clarify the possible presence of hallucinations in OCD without psychotic features, some authors have previously used the term "*obsessive hallucinations*" (hallucinations obsédantes) [8]. It denotes a "hallucination proper accompanied by all the symptoms characteristic of an obsession, including anxiety, distress, and discomfort." Obsessive hallucinations, therefore, have all the characteristics of an obsession but are present in the garb of a hallucination.

Such occurrences have been sparsely reported in the existing literature surrounding phenomenological differences between obsessions and hallucinations. Clinically encountering hallucinations as a part of OCD is generally associated with a poor response to treatment and poor outcomes. Moreover, if the disorder is chronic and the patient presents with only hallucinations as part of psychopathology, the chance of misdiagnosis remains high-ensuing mismanagement with antipsychotics and unwarranted adverse effect burden. However, the cases reported in literature till now have not clarified the possibility of the occurrence of such *obsessive hallucinations* being a *pseudohallucination*. Here, we report one such case in which the patient had reasonably preserved insight into illness and responded well to conventional treatment of OCD despite being treated as a case of primary psychotic disorder initially due to the obscure nature of (pseudo)hallucinations.

Case history

Mr. X, a 22-year-old unmarried male working as a shopkeeper, presented at the psychiatry outpatient with complaints of hearing voices along with occasional episodes of self-smiling for the last five years with poor response to medications. He was apparently well five years back when his family members noticed him smiling when sitting alone. Though initially he did not explain, he later disclosed to the family that he was hearing voices in the absence of others.

He reported hearing the unfamiliar voice of a male child, in clear consciousness, as if speaking to him. The content would often be distressing to him as it would command him to perform actions like "kick a person", "slap a person", "masturbate", etc., but at no point was the patient found to be aggressive or act upon such instructions. During that time, he would hear the voice for about 4-5 hours/day. The frequency and intensity of voices would decrease when the patient is busy with work, interacting with others, watching videos, and playing games on his phone. The content of the voice would be, at times, jocular and would make him laugh. After about a month of experiencing these symptoms, he sought treatment from a local psychiatrist. He was started on tab olanzapine, which was hiked up to 15 mg/day. During this time, he also started hearing the unfamiliar voice of a middle-aged man, telling him that he had done wrong; he should be guilty of his actions, which again was not under his voluntary control. The latter voice lasted for a few months, but the child's voice continued throughout (the patient expressed his guilt later about masturbating excessively during his puberty and hurting a rabbit, which has been the reason why he was being punished in the form of voices). The child's voice increased to 9-10 hours per day, and his screen time (mobile phone usage) increased as he tried to distract himself more.

Mr. X had continued the medications for 1.5 years with only minimal improvement in hearing voices. He experienced weight gain with the medications and hence discontinued it for about a month. On further consultation with the psychiatrist, he was shifted to tab risperidone 2 mg with tab olanzapine 5 mg, tab loxapine 25 mg, tab amisulpride 100mg, and tab trihexyphenidyl 2 mg in combination (The patient had presented to our setting on this regimen). After 1-2 months of starting the treatment, the patient began experiencing periodic uprolling of bilateral eyeballs in clear consciousness without any abnormal body movements, lasting for up to 30 mins and resolving spontaneously, occurring once/twice per week to several times in a single day. The patient explains that he has no control over these movements and denied being due to control by some external agency. However, no significant improvement in hearing voices was found with these medications either.

2.5 years into the illness, family members reported that the patient would be suspicious towards the neighbor, whom he thought to be a threat to his well-being. He accused the neighbor of speaking ill about him and his family, although family members disagreed with his inferences. During this period, the patient was more irritable than his usual self. Such referential ideas lasted for about 2-3 months, to which the patient later reported that the voices would say so, but he didn't find anything suspicious in the neighbor's behavior. These symptoms never occurred thereafter during the course of the illness.

Due to a lack of improvement and the emergence of side effects of episodic uprolling eyeballs, the patient visited our tertiary care facility one year back. Medica-

tions were adjusted, and a diagnosis of primary psychotic illness was considered after a detailed history and examination. He was started on tab Aripiprazole, slowly increased up to 15 mg/ day, with tab olanzapine (up to 15 mg/ day), Vitamin E capsule 400 mg/ day, and tab trihexyphenidyl 2 mg/day. With these medications, the patient reported improvement in uprolling eyeballs as the frequency decreased to 2-3 times every fortnightly. However, there was no significant change in the frequency of the voices.

Due to continued adverse effects and poor response, his medications were further changed to tab risperidone 4 mg/ day, tab trihexyphenidyl 4 mg/ day, and promethazine 25mg/ day. With the increase in doses of anticholinergics, a decrease in the frequency of uprolling eyeballs to one to two times every month was noted. A significant finding was fairly preserved functionality, adequate self-care, and near-normal biological functions. Although the patient did not pursue his academic career (although he completed a course on web designing after graduation), he was working at his father's shop, where he would take care of the overall expenses and finances.

Due to the lack of improvement in hearing voices and the emergence of side effects, we planned further evaluation on an inpatient basis. On admission, detailed history did not reveal any new findings. Detailed serial Mental Status Evaluations were done, which revealed the following: the voice of the child was very clear, well delineated, substantial in nature, and heard in clear consciousness. He found the voice(s) to be repetitive and intrusive. The content was mostly sexual or comprised of profane words or profane comments about others. He had learned to somewhat ignore the voices by using distraction techniques. On further clarification, it was ultimately established that the voices, although not his own, were arising in his inner subjective space. Once this was established, the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) was applied, and the score was found to be 13/ 40 (scored 0 in items for compulsive behaviors, indicating pure obsessions).

With this information at hand, the antipsychotics were tapered off and stopped on day 5, and we started cap fluoxetine 20 mg/ day, which was increased to 40 mg/d after five days. The patient started reporting improvement in the frequency of the voices after a week of starting fluoxetine. tab trihexyphenidyl was stopped on day 7 of admission, but on the very same day, the patient developed three episodes of oculogyric crises and had to be given Inj promethazine, and tab trihexyphenidyl was continued thereafter. On day 12 of admission, the Y-BOCS score was 10/40. During this period, the patient had no oculogyric crises or jaw-opening movements. Perceiving this as a significant improvement, they sought leave against medical advice but agreed to follow up on an outpatient basis regularly. After two weeks, the patient visited the outpatient with no further deterioration, and we increased cap fluoxetine to 60mg/ day. After one month of this visit, he was followed up and reported further improvement regaining his previous baseline mood with no adverse effects. We found a Y-BOCS score of 2/ 40 at this visit.

Discussion

The above-described case seemed to be a therapeutic challenge initially but became a diagnostic challenge later. The pointers that arouse suspicion about the diagnosis were (i) fairly preserved functionality and intact cognitive functions despite persistent hearing of voices (noted as hallucinations in previous treatment records), (ii) despite the chronicity of the voices, the patient never acted upon it or to violation of others' boundaries (where the voices seemed to be commanding), (iii) sensitivity to antipsychotics and development of adverse effects to various molecules, (iv) expression of distress regarding the voices and also being able to distract on certain circumstances as mentioned above (v) response to antiobsessive, and poor response to antipsychotic agents. This case is interesting due to the odd presentation of "hallucination", not in the context of psychosis but OCD. Here, the diagnosis of OCD without psychosis was eventually made. The voices had all the characteristics of hallucinations except that they were occurring in the inner subjective space. Such a presentation in the visual modality would have prompted us to consider a phenomenology of "visual imagery", but we do not have any such characterization for the same in the auditory modality. Most of the imagery in obsessional-compulsive experiences is visual, but infrequently, images that are other than visual have been encountered. Some authors have recognized auditory imagery occurring in the obsessions. For example, textbooks refer to 'tunes in the head'. Akhtar et al. (1975)[8] refer to a young student who could not rid himself of his consciousness of a currently popular tune, assuming an obsessional quality.

Our case provides a sneak peek into a phenomenology that probably entails "auditory imagery" in a voice other than one's own and lacks the typical stereotypic characteristic (of a recurrent tune). As for other forms of imagery, hardly any literature elucidates the same. This might be a proxy indicator for hypothesizing that such imageries in other modalities are rare. Or rather, disturbances in sensory modalities in a background of psychiatric disorder might be a pointer for psychotic phenomena. Case reports of sensory phenomena in an obsessional manner have been recorded where patients complain of seeing dots of feces in their hands (visual), feeling drops of urine in their legs (tactile), and

smelling fetid odors (olfactory). Authors have nonetheless pointed out whether such phenomena were true or pseudohallucinations could be a matter of discussion [2,10]. Another case report of such imagery in tactile modality was found where a middle-aged woman experienced recurrent 'sensations of touch' in her genitals, leading to discomfort and secondary compulsive behaviors. It is perhaps worth pointing out that complaints of such experiences would normally lead to diagnostic considerations and be classified not as obsessive-compulsive but organic or psychotic.

Authors have tried to elucidate such phenomena, and terms like "obsessive hallucinations" or "sensory phenomena in OCD" in the literature [1,11,12]. As pointed out earlier whether such cases were case of true hallucinations isn't clear from the available texts. In our patient, we conceptualized such psychopathology as a case of "pseudohallucination" with an obsessional quality rather than a hallucination. This is in accordance with the descriptions given by Jaspers (true auditory verbal hallucinations occurring in the outer objective space) [13]. Pseudohallucinations have been described as false hallucinations, a phenomenon that could be initially mistaken for a true hallucination. In pseudohallucinations, there is a lack of sensory consistency (objectivity, detail, and corporality), and they are not outside the subject's mind. Other features of pseudohallucinations correspond to the fact that they do not usually persist for long over time and can be modified by will (initiated or interrupted) [14]. However, other authors have provided varying definitions of pseudohallucinations, making it a debatable topic to date.

According to Esquirol, hallucination is held with firm conviction but not pseudohallucination. Kandinsky (1885) described pseudohallucinations as "subjective perceptions similar to hallucinations, with respect to its character and vividness, but that differ from those because these do not have objective reality" [14]. Hare (1973) [15] and Bleuler considered pseudohallucinations in terms of insight. True hallucinations would lack insight, but pseudohallucinations would not. Michea's distinction of AVH from pseudohallucinations is based on sensory richness and the sense of reality [16]. These descriptions again make it pertinent to term the psychopathology our patient was experiencing as "obsessive hallucinations", as our patient seemed to have poor insight about the voices he was experiencing and retaining the sensory richness of the perception. The debate surrounding the usefulness of the term pseudohallucination is fueled even by the fact that no strong neurobiological correlates differentiate it from AVH. In such a scenario, these terms could be best understood as a part of a continuum, with pseudohallucinations being a grey area between real sensory perceptions and true hallucinations.

As far as the neurobiology of disorders as a whole is concerned, the presence of hallucination-related phenomena in OCD suggests a potential overlap with psychotic disorders in terms of dysfunctional dopaminergic circuits. A large number of clinical investigations support the notion of heightened midbrain dopaminergic neurotransmission in OCD [17]. Furthermore, parallels between the functional-circuit theories of OCD and conditions like SCZ indicate more similarities than differences in the underlying mechanisms.

Therefore, patients experiencing such sensory phenomena, which have the qualities of a true perception in an obsessional fashion, might be a different subtype in the spectrum of neurotic and psychotic disorders. Also, the psychopathology might be more appropriately termed "obsessive pseudohallucinations" rather than "obsessive hallucinations", keeping in mind the implications on management protocol. The presence of either of them should encourage the clinician to consider a nonpsychotic disorder and treat it with caution, lest the drugs used produce unwanted side effects or nonresponse. Either outcome would largely compromise the quality of life of our patients.

Conclusion

Although the current classificatory systems in psychiatry have tried to decrease the reliance on descriptive psychopathology for diagnosis, it seems that this might still hold the answer to challenging cases. A thorough elaboration of psychopathology not only helps in understanding the nuances of a patient's mental state but also familiarizes us with phenomena that otherwise might be deemed uncommon or even incompatible in terms of occurrences in particular diagnostic groups. As far as the confusion regarding terminology in descriptive psychopathology, robust studies involving neurobiological correlates of phenomena might help shed some light in the future.

Conflict of interest statement

The authors declare no conflict of interest.

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Authors' contributions

SS, DN, and AD were all involved in the diagnosis and management of the case. AD was responsible for the overall supervision of the patient. SS wrote the primary draft, and DN supplemented it with further details. AD corrected the final draft of the report.

Consent for publication

Written informed consent was obtained from the patient for the publication of this case report.

Ethical consideration

Since this is a case report, there is no need for ethical approval. Written informed consent was obtained from the patient to publish this case report.

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