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REVIEW ARTICLE **OPEN ACCESS**

Clinical Aspects and Management of Patients Experiencing Hallucinations

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ABSTRACT

The literature review on hallucinations is discussed, along with how they affect people with various psychiatric conditions, neurological issues, and healthy individuals; causation and types of hallucinations. Additionally, the diagnostic value of hallucinations is examined. There is a brief discussion of the various hallucination management techniques.

KEYWORDS: *Clinical aspects; hallucinations; management of hallucination.*

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INTRODUCTION

Hallucinations are sensory impressions that occur when there are no external stimuli. The perception of sounds or sights that are not actually present is one example. A recent bereaved person who sees' the deceased could be one instance. One or more of the senses may be impacted by these perceptions[1].

DEFINITION

"A false perception, which is not a sensory distortion or misinterpretations but which occurs as the same time as real perceptions[2]" - (Jaspers)

CAUSES

Numerous physical and psychological factors can contribute to this. They consist of the following [3-5]:

1. Changes in brain function brought on by brain disease or trauma can produce hallucinations
2. Hallucinations in youngsters and the elderly can develop from fever brought on by an infection;
3. Hallucinations may be brought on by severe medical conditions including brain tumours, liver or kidney failure;
4. Chronic stress can impair thinking and induce hallucinations;
5. Physical and emotional fatigue brought on by lack of sleep and sleep exhaustion, can also trigger hallucinations;
6. Sensory deprivation occurs when the brain is not exposed to enough external input to generate perceptions. It might attempt to make up for this by developing hallucinatory perceptions, which can happen to blind or deaf persons;
7. Hallucinogenic drugs including mescaline LSD, and psilocybin (found in "magic" mushrooms) may cause hallucinations. Cannabis also produces hallucinations;
8. A few prescribed drugs also cause hallucinations
9. Severe dehydration
10. Delirium or Dementia
11. Epilepsy that involves a part of the brain called the temporal lobe (odor hallucinations are most common)
12. Fever, especially in children and the elderly
13. Narcolepsy and sleep disturbances
14. Psychiatric illness, such as schizophrenia, bipolar disorder, psychotic depression

TYPES OF HALLUCINATIONS [1, 2]

Visual hallucinations are experienced as seeing something which is actually not there. These could be elementary, partial or completely organized and are most commonly found in acute organic states. These are mostly experienced isolated from auditory hallucinations.

Auditory hallucinations are experienced as hearing voices which does not exist. It could be elementary or partial or completely organized voices.
Auditory hallucinations are of three types namely thought echo, in second person and third person.
Olfactory hallucinations are not very common and causes the individual to experience the presence of smells that are actually not present.
Tactile Hallucinations are experienced by an individual as if they are sensing
something with their skin in absence of the stimulus.
Kinesthetic hallucinations, is the one in which where the person experiences sensations in respect to the movement for example, they may experience that some part of their body is moving when actually it isn't.

CLINICAL ASPECTS OF HALLUCINATIONS
Schizophrenia
According to the IPSS, 70% of schizophrenia patients reported having hallucinations. Auditory and visual hallucinations are the most frequent types in schizophrenia. Less often reported sensations include tactile, olfactory, and gustatory. In visual hallucinations caused by schizophrenia, deformed persons, body parts, illegible objects, and overlaid objects are more common [6, 7].
Mood disorders
Patients with severe depression may occasionally experience auditory hallucinations, but these experiences are usually transient, limited to one worded or short phrases, and usually consistent with the patient's depressed mood. Auditory hallucinations are another symptom of mania. In mania, auditory hallucinations can also happen. The sounds typically address the patient directly, and the messages are consistent with the patient's unusually heightened mood. Depression has been associated with negative hallucinations [6, 7].
Postpartum psychosis
Postpartum disorders' symptoms are primarily related to how the woman feels about her new child and her motherly responsibilities. A mother experiencing hallucinations might hear her infant weeping or hear voices instructing her to kill the child or criticising her for not being a good mother [8].
Psychoactive substance induced Hallucinations
Visual hallucinations are most frequently brought on by psychoactive substances. Usually, unformed visual impressions, such as changes in colour, size, shape, and movement, come before these. Typically, the pictures are abstract, such lines, circles, and stars. The individual thereafter has vivid, colourful visions. Substance-induced psychoses are characterised by unformed and hazy auditory hallucinations. During cocaine and amphetamine intoxication, tactile hallucinations of insects crawling up the skin are common. Reflex hallucinations occur when a substance is in your system [7, 8].
Delirium Tremens
Visual hallucinations, such as seeing cats, dogs, insects, snakes, or rats, or signs and shapes, are a common occurrence during delirium tremens (multicolored patterns, chalk writing on slate). There is a possibility of experiencing tactile, auditory, musical, and lilliputian hallucinations [9]. Although musical hallucinations can be enjoyable, most hallucinations are unpleasant and terrifying [10].
Alcoholic hallucinosis
Hallucinations, delusions, abnormalities in psychomotor activity, misidentification, and aberrant mood are the hallmarks of the syndrome [8, 10].
Alzheimer's disorder
Hallucinations are common in Alzheimer's disease (AD), with prevalence rates ranging from 12 to 53%. Visual hallucinations are common, but there have also been reports of all other types of hallucinations. The majority of hallucinations occur in the moderate to severe phases of the disease [11].

DIAGNOSTIC SIGNIFICANCE OF HALLUCINATIONS
Its diagnostic relevance is minimal in light of the wealth of phenomenological information we currently have on hallucinations.
1. ICD-10 and DSM-IV both list hallucinations as a key symptom of psychosis.
2. The ICD-10 diagnostic criteria for schizophrenia use audible hallucinations as thought echo, and those in the third person, and are commenting type.
3. Hallucinations under anaesthesia may indicate a specific type of uncommon schizophrenia.
4. Alcohol-related hallucinations can distinguish delirium tremens from alcoholic hallucinosis phenomenologically, but it is very difficult to tell the last one from schizophrenia.
5. With the exception of organic brain diseases, where visual hallucinations predominate, auditory hallucinations are most prevalent across all demographics [8, 12].

TREATMENT OF HALLUCINATIONS

Treatment should start with least radical therapy starting from psychoeducation, teaching adaptive coping techniques, using cognitive behaviour therapy to reduce fear and obedience to the voices, treatment with antipsychotic medications, using Transcranial magnetic stimulation, and last Electro convulsive therapy.

Psychoeducation

As a helpful tool for determining what the patient, caregivers and their colleagues are experiencing and how the issue may have developed, psychoeducation is a important technique. This is specifically valid for stigmatising conditions like schizophrenia and experiences like hallucinations. In fact, the majority of people think that those who "hear voices" should be locked up because they think they are aggressive and unstable. Hallucination-related distress is significant and contributes to a variety of issues that require attention[13]. Medication and psychotherapy can reduce hallucination-related distress on an individual basis. On a cultural level, however, hallucination-related discomfort might also be lessened. That is, it would be considerably simpler for people who have hallucinations to effectively regulate their experiences if views toward hallucinations in general were less harmful and unpleasant.

Therefore, public awareness campaigns about psychotic experiences directed at the general population, educational institutions, and primary healthcare providers are also a crucial intervention option. A wide range of individuals experience a reduction in stigmatising views after taking brief educational courses on mental illness [14].

Pharmacological treatment

Antipsychotics work best when treating Hallucination as a symptom of functional or pathological psychosis. Every antipsychotic work, albeit newer antipsychotics have an advantage over older antipsychotics[8]. Hallucination treatment follows the same general principles as medication for psychosis. In schizophrenia, 25–30% of auditory hallucinations are resistant to treatment with conventional antipsychotic medications [15]. Even with the introduction of more modern antipsychotics, a sizable portion of patients still experience hallucinations [16].

Transcranial magnetic stimulation

Hallucinations in schizophrenia have been suggested to be treated with repetitive TMS (rTMS), a form of transcranial magnetic stimulation (TMS)[17]. In comparison to fast rTMS (more than five Hz used to treat depressed mood), which increases neuronal activity, slow rTMS (1Hz) is typically used to cure hallucinations because it lowers neuronal excitability. Studies demonstrating rTMS's effectiveness for hallucinations are insufficient [17].

Cognitive behavioural therapy

Cognitive behaviour therapy for patients with psychosis aims to lessen suffering, impairment brought on by psychosis, to lessen psychological distress and to assist patient to understand psychosis better, to encourage the patient's better contribution in the management of relapse risk and social disability [18].

CBT was conceptualised consisting of 6 phases:

1. A therapeutic connection must be established and maintained,
2. Cognitive-behavioral ego strengthening mechanisms must be used,
3. A new knowledge of psychosis must be developed,
4. Delusions and hallucinations must be addressed,
5. Anxiousness, sadness, and negative self-criticisms must be addressed,
6. The threat of relapse and social impairment must be managed.

One major drawback of CBT is that it only addresses responses to the experiences (such as distress), not the hallucinations themselves. Moreover, although CBT is more successful than standard treatment, its superiority is less clear when compared to alternative therapies that make use of comparable quantities of one-on-one therapist attention. CBT did not enhance patients' depression, negative symptoms, or social functioning [19].

HALLUCINATION-FOCUSED INTEGRATIVE TREATMENT

The treatment focuses on hallucination. Multiple therapies are used to maximize control of persistent auditory hallucinations. There are a number of different treatment strategies that it integrates like CBT, Psychoeducation, training coping strategies, supportive psychotherapy, antipsychotic medications and mobile crisis intervention. The intervention uses 20 one-hour sessions spread over a span of nine to twelve months. HIT is distinctive from most CBT programs in that client and his family members get cognitive mediations. The positive impacts final as long as 9 months after treatment. The positive effects of HIT last as long as 9 months even after clinical intervention [20].

CONCLUSION

Hallucinations are typically considered to be signs of psychosis. However, there is a wealth of evidence to substantiate hallucination in non-psychotic circumstances. These mechanisms are still unresolved. Since the idea of reality differs among cultures and there is a chance that hallucination will be accepted, it is crucial to consider the cultural context while evaluating hallucination. A stronger understanding of the psychological therapy of hallucination is required in addition to efficient pharmaceutical treatment, which can assist us in dealing with refractory hallucination[23].

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