Case Report

Visual Hallucinations in Mania

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ABSTRACT

Visual hallucinations occur in a wide variety of neurological and psychiatric disorders, including toxic disturbances, drug withdrawal syndromes, focal central nervous system lesions, migraine headaches, blindness, schizophrenia, and psychotic mood disorders. Visual hallucinations are generally assumed to characteristically reflect organic disorders and are very rare in affective disorders. Here, we present a case of visual hallucinations in a young female with bipolar illness during the manic phase.

Key words: *Mania, visual hallucinations, bipolar*

INTRODUCTION

Visual hallucinations occur in a wide variety of neurological and psychiatric disorders, including toxic disturbances, drug withdrawal syndromes, focal central nervous system lesions, migraine headaches, blindness, schizophrenia, and psychotic mood disorders. Although, visual hallucinations are generally assumed to characteristically reflect organic disorders, they are seen in one-fourth to one-half of schizophrenic patients, often, but not always in conjunction with auditory hallucinations. Visual hallucinations range from simple and elemental, in which hallucinations consist of flashes of light or geometrical Figures to elaborate visions such as a flock of angels.

It is often difficult to decide whether the full criteria for the presence of hallucinations have been fulfilled in the visual modality (Sims). Some of the earlier writers used the term "hallucination" for other visual abnormalities that occurred and the prevalence of visual hallucinations reported in psychiatric illnesses was much higher than reported in studies which used a more stringent definition of hallucination. The current understanding is that visual hallucinations are very uncommon in pure psychiatric illness (Persaud and Cutting). Visual hallucinations are not reckoned to occur in affective psychoses uncomplicated by organic factors (Sims).

Here, we describe a case of a female who developed visual hallucinations during an episode of uncomplicated mania.

Access this article online

Website: www.ijpm.info

Quick Response Code

DOI: 10.4103/0253-7176.85399

CASE REPORT

Ms. G, a 22-year-old female, final year BA student, from an educated urban background, who was on treatment for bipolar disorder presented to the hospital with a one week history of over -talkativeness, increased energy, increased self esteem, and sleeping for only 3 hours and feeling refreshed after that. She had also become increasingly irritable over the last week, often snapping at her parents over trivial issues. She was able to see images of God and believed she should be the chief minister of the state. She was also prophesying the death of her grandmother. She could see her grandmother's dead body lying on her funeral bed in the drawing room of her house, dressed

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in white with flower garlands around her neck and people sitting around her weeping. She saw relatives and family friends come to pay their last respects and leaving after offering her and other family members their condolences. She herself would begin weeping on witnessing the sight and had to leave the room. Every time she went back to the room she would again see the same scene. She clearly stated this scene was different from her seeing the face of God (as she had seen in past episodes of illness), during which she only saw the face and the rest of the room would blank out.This scene of the grandmother's death on other hand was (as if) happening in reality, where she clearly saw all the people and objects in the room in full detail and could interact with them. This disturbed the patient as she realized her grandmother was still alive and lead her to believe that her grandmother would die by the end of the week. Despite this, she continued to feel cheerful at all other times (except when she saw the scene) and felt that she should become the chief minister. She demanded that her parents take her shopping and wished she could attend parties every day.

The patient was diagnosed as having bipolar disorder 5 years ago, when she had manic episode, after death of her 16 years old brother that recovered with 1 month of treatment. Since then, the patient has been on regular treatment with mood stabilizers. She had a second episode of mania lasting 15 to 20 days in 2008, and a depressive episode in 2010 that required admission to the hospital for 5 days. In her previous manic episodes, she had grandiose ideas and could see the face of God when she was in bed. Although she stated that this was a face she saw and not just a thought, her description of these faces fitted the description of visual imagery, with her seeing the faces only when her eyes were closed and the faces disappearing when she opened her eyes. At no point of time in the past had she been able to see a scene like the one she described in the current episode.

There is no history of any substance abuse, seizures, loss of consciousness or head injuries. There were no signs of infection. She had no history of any other physical illness. She is the eldest of the 3 siblings with a brother having mental retardation, who expired 5 years ago due to kidney failure. No other family history of psychiatric illness was present.

Examination revealed an obese young girl who was extremely friendly with everyone in the hospital with an infectious jocularity with increased psychomotor activity. She described her mood as happy, although, she was sometimes worried about her grandmother, but appeared cheerful throughout the interview with occasional irritable outbursts towards her mother. She had an increased self esteem believing she could easily become the chief minister and believed she could predict the future which was mainly limited to her prophesying that her grandmother would die by the end of the week. She gave a vivid description of her grandmother on the funeral bed. Her higher mental functions were intact except impaired attention and concentration and there was never any suggestion of impairment of consciousness during the illness. Her young mania rating scale (YMRS) score was 25 at admission.

A possibility of a comorbid organic disorder was entertained in view of the visual hallucinations, and the patient was worked up for the same. Physical examination was normal with no neurological deficits or autonomic changes. All investigations including complete blood count, thyroid functions, renal and hepatic functions, blood sugar level, electrocardiography (ECG) and electrolytes came back normal. Computerized tomography (CT) scan of the brain and electroencephalogram (EEG) studies showed no abnormalities.

Patient was treated with oral alproate 1500 mg/day and oral isperidone, hiked up to 4 mg/day. Quetiapine was added and raised up to 1200 mg, especially, keeping in mind the patient's complaint of insomnia. She showed a decrease in the intensity of symptoms and sleep improved over one week and she was discharged from the hospital (YMRS=9), no longer feeling that she could predict her grandmother's death. She no longer saw the faces of God or see/hear the scene of her grandmother's death once she went home.

DISCUSSION

Visual hallucinations are rare in psychiatric illnesses, so much so that they should raise doubt as to the diagnosis. Toxic and metabolic disorders are among the most common causes of visual hallucinations. The diagnostic value of visual hallucinatory experiences in all age groups remains uncertain (Rothstein; Lowe; Berrios and Brook). The belief that they are indicative of cerebral pathology is only partially substantiated (Berrios). Lowe (1973) studied 60 patients divided into equal number of patients with differing diagnoses to study the phenomenology of hallucinations to assess if it aided in differential diagnosis. He found that manic depressive patients tend to be younger to report mainly auditory and visual hallucinations (the females reporting rarer types), which are less frequent and briefer, believed to be less real in retrospect, less controllable, sometimes involving marked changes in time sense and with vague causes ascribed, but nearly always considered to be experienced only by themselves.

Patients with organic visual hallucinations, on the other hand, tend to report two or three hallucinations, many of which are of mixed modality, predominate over ordinary perception, are not controllable, involve no change in time sense, and are sometimes believed to be shared by persons beyond sensory range.

According to Sims, it is possible in most instances to see how psychotically disordered fantasy accounts for the content of visual experiences. Scenic hallucinations are more common in psychiatric disorder associated with epilepsy (ruled out in this case). Often visual hallucinations are isolated and do not have accompanying noises or voices. Sometimes, however, visual and auditory hallucinations form a coherent whole.

In this case, it was interesting to have the presence of elaborate visual hallucinations in bipolar disorder during the manic phase. Although the patient interpreted the hallucination to mean that she had a power to foretell the future, the hallucination itself was associated with sadness and tearfulness, a mood which was not seen at any other point of the episode.

FOR FURTHER READING

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How to cite this article: Chakrabarty A, Reddy MS. Visual hallucinations in mania. Indian J Psychol Med 2011;33:71-3.

Source of Support: Nil, **Conflict of Interest:** None.