
Musical obsession or musical hallucination? a psychopathological and psychopharmacological reflection based on a fictional vignette

Obsessão ou alucinação musical? uma reflexão psicopatológica e psicofarmacológica a partir de uma vinheta fictícia

Obsesión o alucinación musical? una reflexión psicopatológica y psicofarmacológica a partir de una viñeta ficticia

1 Rodrigo Nicolato  - [ORCID](#) - [Lattes](#)

2 Jussara Mendonça Alvarenga - [ORCID](#) - [Lattes](#)

Affiliation of authors: **1** [Full Professor, Department of Psychiatry, School of Medicine, Federal University of Minas Gerais, Belo Horizonte, MG, Brazil]; **2** [Department of Psychiatry, Military Police Hospital of Minas Gerais, Belo Horizonte, MG, Brazil].

Chief Editor responsible for the article: César Augusto Trinta Weber.

Authors contributions according to the [Taxonomia CRediT](#): Nicolato R, Alvarenga JM [1, 5, 10, 11, 12, 13, 14].

Disclosure of potential conflicts of interest: declare no

Funding: none

Approval Research Ethics Committee (REC): not applicable

Received on: 2026/07/01

Accepted on: 2026/07/02

Published on: 2026/07/07

How to cite: Nicolato R, Alvarenga JM. Musical obsession or musical hallucination? a psychopathological and psychopharmacological reflection based on a fictional vignette. *Debates Psiquiatr.* 2026;16:1-10, e1637. <https://doi.org/10.25118/2763-9037.2026.v16.1637>

BRIEF COMMUNICATION

When music becomes a symptom

Music is one of the most universal forms of memory, affect, and identity. Therefore, not every repetitive musical experience is pathological. Songs that get “stuck” in the mind, melodic fragments that return spontaneously, and involuntary musical memories are part of ordinary human experience. The clinical problem begins when music ceases to be a passing memory or

annoyance and starts to occupy psychic life in a persistent, intrusive, distressing, or perceptually unusual way.

In this territory, the diagnostic question is deliberately provocative: is it musical obsession or musical hallucination? The answer is not merely semantic. If the clinician calls an obsession a hallucination, the result may be psychotic stigma, misdirected investigation, and nonspecific treatment. If the clinician calls a hallucination an obsession, hearing impairment, epilepsy, dementia, medications, sensory deprivation, or another neurological or medical condition may remain unexplored. The boundary between these phenomena therefore requires careful psychopathology and therapeutic prudence.

The literature on musical obsessions describes intrusive, repetitive, unwanted musical phenomena associated with distress, often within the obsessive-compulsive spectrum [1 - 2]. Literature comparing musical obsession and musical hallucination highlights the clinical relevance of differential diagnosis [3]. Reviews on musical hallucinations describe the experience of hearing music without a corresponding external stimulus, frequently associated with hearing impairment, older age, neurological conditions, medications, and neurocognitive disorders, without necessarily implying psychosis [4, 5, 6, 7]. [DSM-5-TR](#) and [ICD-11](#) help organize syndromes, but they do not replace the psychopathological interview [8, 9]. This article proposes a clinical and psychopharmacological reflection on this boundary, based on entirely fictional clinical vignettes created solely for didactic purposes and not inspired by a real case.

Fictional clinical vignettes: three ways of listening to the same complaint

Vignette A: a retired teacher, socially active and with no history of psychotic disorder, seeks care saying that “a song will not leave my head.” She describes the phenomenon as repetitive, unwanted, and exhausting. The experience increases when she tries to suppress it, improves transiently when she is distracted, and is accompanied by anxiety, irritability, and mental rituals to “replace” the melody. When asked, she locates the music “in the mind,” recognizes the absurd character of the discomfort, and does not believe that anyone is transmitting sounds. Here, the obsessive-compulsive formulation gains strength.

Vignette B: an older woman with progressive hearing loss and tinnitus reports hearing old hymns at dusk, especially in a quiet environment. The music seems to come from the next room, but she finds no sound source. There are no delusions, formal thought disorder, behavioral

disorganization, or persecutory conviction. The phenomenon has perceptual quality, depends on silence, and is associated with auditory deprivation. Here, the hypothesis of musical hallucination due to sensory release should be investigated before any psychotic label.

Vignette C: a patient with depressive symptoms, insomnia, and recent medication change begins to report repetitive musical fragments, sometimes as intrusive thought and sometimes as almost external sound. The experience is distressing, but insight fluctuates. This vignette is closest to everyday clinical work: psychopathology does not always fit clean boxes. The same complaint may include obsessive, perceptual, affective, pharmacological, and neurosensory components.

The three vignettes are entirely fictional. They were not built from charts, consultations, clinical memories, or case composites. They are used to show that the question “obsession or hallucination?” has value only when it forces the clinician to describe the experience, not when it becomes a quick answer.

The central point is that the way the clinician asks changes the diagnosis: “Does the music come from outside or inside?”, “Do you believe someone is transmitting it?”, “Do you try to resist it?”, “Is the experience perceived as absurd or as real?”, “Is there hearing loss?”, “Has medication changed?”, “Is there cognitive decline?”, “Are there seizures, sleep disturbance, or substance use?”.

The phenomenology of musical obsession

Musical obsession approaches the obsessive-compulsive field when music appears as intrusive, repetitive, unwanted, and ego-dystonic mental content. The patient usually recognizes that the experience is internal, excessive, or senseless, even if unable to stop it. Anxiety and attempts at resistance are important elements: the person tries to suppress, neutralize, replace, or “correct” the music, but this effort may increase the salience of the phenomenon.

Taylor et al. described musical obsessions as neglected clinical phenomena, often confused with hallucinations, ruminations, or normal musical experiences [1]. Later reviews reinforced that music may appear both as a trigger and as the content of obsessive-compulsive symptoms [2]. The expression stuck song syndrome is useful for clinical communication, but it is not a diagnosis: a song stuck in the mind may be banal; it becomes clinically relevant when there is distress, functional impairment,

persistence, resistance, and a relationship with anxiety or mental compulsions [10].

Clinical reports and discussions show that musical obsessions may arise in diverse contexts, including auditory changes, response to clomipramine, complex electrophysiological presentations, and late onset [11, 12, 13, 14]. From a classificatory perspective, neither [DSM-5-TR](#) nor [ICD-11](#) recognizes “musical obsession” as an autonomous category [8 - 9]. The phenomenon should be described as a possible manifestation of obsessions within the obsessive-compulsive spectrum when syndromic criteria are met. This caution matters: diagnosing obsessive-compulsive disorder requires more than identifying repetitive music; it requires assessment of time spent, distress, impairment, insight, neutralization, compulsions, and differential diagnoses.

The phenomenology of musical hallucination

Musical hallucination is a perceptual experience of music without a corresponding external source. It may be simple or complex, familiar or unknown, brief or persistent. Contrary to popular stereotypes, musical hallucination does not automatically mean schizophrenia or psychosis. Many patients retain partial or full insight, recognizing that the music does not come from the environment, although it is perceived with sensory quality.

Reviews of musical hallucinations highlight their association with hearing impairment, sensory deprivation, brain lesions, epilepsy, neurocognitive disorders, medications, and psychiatric conditions [4, 7, 15 - 16]. In older adults, auditory assessment is particularly relevant. Reduced sensory input may favor musical perceptual phenomena in a way analogous to other forms of sensory release. Asking about hearing, tinnitus, hearing aids, and sensory isolation is not a detail; it is part of the diagnosis.

Medication and substance review is also essential. Certain drugs may precipitate or worsen perceptual phenomena in vulnerable individuals, and polypharmacy in older adults increases this risk. The presence of musical hallucination should open medical, neurological, auditory, and psychiatric investigation.

How to differentiate during clinical interview

The distinction should not depend on a single question. The first axis is externality: is the music experienced as thought/mental imagery or as sound perception in external space? The second is insight: does the patient

recognize the internal or strange nature of the experience, or believe literally that there is a hidden external source? The third is affective relationship: are there anxiety, disgust, fear, irritation, and resistance, suggesting obsession, or a more passive perceptual experience, suggesting hallucination? The fourth is context: is there hearing loss, cognitive change, epilepsy, neurological disease, medication change, depression, anxiety, obsessive-compulsive disorder, or substance use?

Perhaps the most useful question is not “is it obsession or hallucination?”, but “what is the psychopathological architecture of the musical experience?”. In some patients, the phenomenon may occupy an intermediate zone: intrusive like an obsession, sensory-like as a hallucination, and interpreted with variable insight. In such cases, formulation should be descriptive, provisional, and revisable. Diagnostic haste may be more harmful than well-conducted doubt.

A practical matrix may help: musical obsession is supported by intrusiveness, ego-dystonia, resistance, anxiety, and recognition of internality; musical hallucination is supported by perceptual quality, externality, association with hearing impairment or neurological conditions, and weaker relation to obsessive neutralization. None of these elements is absolute in isolation.

DSM-5-TR and ICD-11: how to classify without impoverishing clinical practice

[DSM-5-TR](#) and [ICD-11](#) do not provide a specific code for “musical obsession” or “musical hallucination” [8 - 9]. This absence does not mean that the phenomenon is irrelevant; it means that it should be formulated within recognizable syndromes or as a transdiagnostic symptom. In an obsessive formulation, the question is whether there is obsessive-compulsive disorder, another obsessive-compulsive-related disorder, anxiety disorder, depression with rumination, or a nonsyndromic intrusive phenomenon. In a perceptual formulation, the question is whether there is a psychotic disorder, mood disorder with psychotic symptoms, neurological condition, epilepsy, neurocognitive disorder, hearing impairment, intoxication, withdrawal, or medication effect.

This distinction protects the patient. The word “hallucination” may be technically correct and still clinically imprecise if communicated as a synonym for psychosis. Likewise, the word “obsession” may provide false reassurance if it conceals a perceptual phenomenon related to auditory deprivation, epilepsy, or neurocognitive disease. Competent use of

classifications requires categorical diagnosis to follow phenomenological description, not precede it.

For editorial purposes, this is the provocative point: music invading the mind is not automatically obsession; music that seems to play in the environment is not automatically psychosis. Diagnosis emerges from the relationship between form, content, insight, organic context, temporal course, distress, and therapeutic response.

Psychopharmacological treatment: treat the formulation, not only the music

Treatment should follow the clinical formulation. When obsessive-compulsive phenomenology predominates, the logic approaches treatment of obsessive-compulsive disorder: psychoeducation, cognitive-behavioral therapy with response prevention when applicable, and anti-obsessional pharmacological strategies. Selective serotonin reuptake inhibitors and clomipramine are classic options for obsessive-compulsive disorder, used at appropriate doses and duration, with attention to tolerability, interactions, and comorbidities. Reports of musical obsession describe improvement with anti-obsessional approaches, but evidence remains limited and does not allow a specific algorithm for all cases [1, 2, 12, 14]. In older adults, choosing among sertraline, escitalopram, fluvoxamine, fluoxetine, paroxetine, or clomipramine is not cosmetic; it should consider anticholinergic burden, QT interval, hyponatremia, fall risk, drug interactions, and adherence.

When intense anxiety, insomnia, comorbid depression, or rumination are present, treatment must address the whole syndrome. Low-dose antipsychotics may be considered as augmentation in resistant obsessive-compulsive disorder or when perceptual phenomena, severe distress, insomnia, or specific comorbidities are present, but their use should be cautious, especially in older adults, because of metabolic, motor, cognitive, and cardiovascular risks. Risperidone and aripiprazole have rationale as augmenting agents in resistant obsessive-compulsive disorder, but extrapolation to musical obsession should be individualized. The aim is not automatically to “treat psychosis,” but to modulate well-defined target symptoms.

When musical hallucination predominates, priorities may differ: correct or compensate for hearing impairment, reduce sensory deprivation, review medications, treat depression, anxiety, epilepsy, or neurocognitive disorder, and only then consider specific psychotropics. Reviews show

heterogeneous responses to antipsychotics, antidepressants, anticonvulsants, acetylcholinesterase inhibitors, and auditory interventions, depending on presumed etiology [4, 15 - 16]. The therapeutic question is therefore not “which medication removes music?”, but “which likely mechanism sustains this phenomenon in this patient?”.

In geriatric psychiatry, prudence is decisive. Polypharmacy may both treat and produce symptoms. Medication initiation should be accompanied by clear goals, periodic review, attention to interactions, falls, anticholinergic effects, sleep changes, metabolic syndrome, and adherence. In persistent musical phenomena, good formulation may save unnecessary medications.

Why the topic is provocative

The topic is provocative because it challenges a simplistic division between thought and perception. Music may be memory, imagery, obsession, hallucination, sensory release phenomenon, neurological symptom, affective expression, or all these elements in different proportions. Psychiatric practice becomes poorer when this complexity is reduced to a quick label. It is also provocative because diagnosis may produce stigma. Calling a musical experience a hallucination without qualification may frighten patients and families, suggesting psychosis where an obsessive, auditory, or neurological phenomenon may exist. Conversely, minimizing the experience as “a song stuck in the head” may invalidate real suffering and delay investigation. Good practice lies between these extremes: taking the complaint seriously without premature pathologization.

CONCLUSION

Persistent musical phenomena require refined clinical listening. The distinction between musical obsession and musical hallucination is not an academic detail; it guides differential diagnosis, organic investigation, psychotherapeutic approach, psychopharmacological treatment, and communication with the patient. A fictional vignette allows discussion of this boundary without risk of identification and without turning a real case into narrative material. The question “musical obsession or musical hallucination?” should be sustained long enough for the experience to be described with precision. When music is intrusive, ego-dystonic, resisted, and anxiogenic, the obsessive formulation gains strength. When it is perceptual, externalized, and associated with hearing impairment, neurological alteration, medication, or cognitive decline, musical hallucination should be prioritized. In both scenarios, treatment should be individualized, parsimonious, and guided by an explicit clinical hypothesis.

REFERENCES

- 1. Taylor S, McKay D, Miguel EC, de Mathis MA, Andrade C, Ahuja N, Sookman D, Kwon JS, Huh MJ, Riemann BC, Cottraux J, O'Connor K, Hale LR, Abramowitz JS, Fontenelle LF, Storch EA. Musical obsessions: a comprehensive review of neglected clinical phenomena. *J Anxiety Disord.* 2014;28(6):580-9. <https://doi.org/10.1016/j.janxdis.2014.06.003> PMid:24997394
- 2. Truong TPA, Applewhite B, Heiderscheit A, Himmerich H. A Systematic Review of Scientific Studies and Case Reports on Music and Obsessive-compulsive Disorder. *Int J Environ Res Public Health.* 2021;18(22):11799. <https://doi.org/10.3390/ijerph182211799> PMid:34831558 PMCID:PMC8618048
- 3. Costa OPF, Dalcim ML, Smaira SI, Lovadini GB. Musical hallucination or musical obsession? A differential diagnosis between two cases. *Dement Neuropsychol.* 2024;18:e20230073. <https://doi.org/10.1590/1980-5764-dn-2023-0073> PMid:38933080 PMCID:PMC11206231
- 4. Coebergh JAF, Lauw RF, Bots R, Sommer IEC, Blom JD. Musical hallucinations: review of treatment effects. *Front Psychol.* 2015;6:814. <https://doi.org/10.3389/fpsyg.2015.00814> PMid:26136708 PMCID:PMC4468361
- 5. Linszen MMJ, van Zanten GA, Teunisse RJ, Brouwer RM, Scheltens P, Sommer IEC. Auditory hallucinations in adults with hearing impairment: a large prevalence study. *Psychol Med.* 2019;49(1):132-39. <https://doi.org/10.1017/S0033291718000594> PMid:29554989
- 6. Moseley P, Alderson-Day B, Kumar S, Fernyhough C. Musical hallucinations, musical imagery, and earworms: A new phenomenological survey. *Conscious Cogn.* 2018;65:83-94. <https://doi.org/10.1016/j.concog.2018.07.009> PMid:30077016 PMCID:PMC6204882
- 7. Badcock JC, Dehon H, Laroï F. Hallucinations in Healthy Older Adults: An Overview of the Literature and Perspectives for Future Research. *Front Psychol.* 2017;8:1134.

<https://doi.org/10.3389/fpsyg.2017.01134> PMid:28736541
PMCID:PMC5500657

- 8. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) [Internet]. Washington, DC: American Psychiatric Association Publishing; 2022.
<https://doi.org/10.1176/appi.books.9780890425787>
- 9. World Health Organization. International Classification of Diseases 11th Revision (ICD-11) [Internet]. Geneva: World Health Organization; 2022. <https://icd.who.int/pt/>
- 10. Euser AM, Oosterhoff M, van Balkom I. Stuck song syndrome: musical obsessions - when to look for OCD. Br J Gen Pract. 2016;66(643):90. <https://doi.org/10.3399/bjgp16X683629>
 PMid:26823252 PMCID:PMC4723199
- 11. Islam L, Scarone S, Gambini O. Obsessive-compulsive disorder presenting with musical obsessions in otosclerosis: a case report. J Med Case Rep. 2014;8:384. <https://doi.org/10.1186/1752-1947-8-384> PMid:25418908 PMCID:PMC4304165
- 12. Matsui T, Matsunaga H, Ohya K, Iwasaki Y, Koshimune K, Miyata A, Kiriike N. Clinical features in two cases with musical obsessions who successfully responded to clomipramine. Psychiatry Clin Neurosci. 2003;57(1):47-51. <https://doi.org/10.1046/j.1440-1819.2003.01078.x> PMid:12519454
- 13. Praharaj SK, Goyal N, Sarkar S, Bagati D, Sinha P, Sinha VK. Musical obsession or pseudohallucination: Electrophysiological standpoint. Psychiatry Clin Neurosci. 2009;63(2):230-34. <https://doi.org/10.1111/j.1440-1819.2009.01926.x> PMid:19335393
- 14. Tan Y, Meng A, Kaur K. Late-Onset Musical Obsession: A Case Report of an Elderly Patient Treated in an Outpatient Psychiatry Clinic. Cureus. 2024;16(10):e71369.
<https://doi.org/10.7759/cureus.71369>
- 15. Blom JD, Coebergh JAF, Lauw RF, Sommer IEC. Musical Hallucinations Treated with Acetylcholinesterase Inhibitors. Front

Psychiatry. 2015;6:46. <https://doi.org/10.3389/fpsy.2015.00046>
PMid:25904872 PMCID:PMC4387860

- ↑
↑ 16. Coebergh JAF, Lauw RF, Sommer IEC, Blom JD. Musical hallucinations and their relation with epilepsy. J Neurol. 2019;266(6):1501-15. <https://doi.org/10.1007/s00415-019-09289-x> PMid:30972497 PMCID:PMC6517562