# *All That Glitters is Not Gold: Clinical Perspectives on Psychologic Seizures*

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*For the typical practicing neurologist or other physician who deals regularly with neurological conditions, nonepileptic psychogenic seizures (PNES) are perhaps most often encountered as something of a hidden syndrome. However, if the syndrome is often hidden, the symptoms of the disorder and their manifold repercussions are not. Frustrating, seemingly refractory patients who do not respond as expected to reasonable medication regimens, angry and confused families, and enormous costs in terms of time and energy for all involved (including the patient, who then goes without appropriate treatment) are quite typical and ordinary sequelae of PNES.*

*Introduction.* For the typical practicing neurologist or other physician who deals regularly with neurological conditions, nonepileptic psychogenic seizures (PNES) are perhaps most often encountered as something of a hidden syndrome.[1] However, if the syndrome is often hidden, the symptoms of the disorder and their manifold repercussions are not. Frustrating, seemingly refractory patients who do not respond as expected to reasonable medication regimens, angry and confused families, and enormous costs in terms of time and energy for all involved (including the patient, who then goes without appropriate treatment) are quite typical and ordinary sequelae of PNES.

Precise incidence and prevalence rates for PNES are not available for a condition that until the advent of 24-hour video-EEG telemetry had no highly accurate and reliable way to be differentially diagnosed. Simple visual diagnosis of PNES has long been known to be frequently inaccurate. At our tertiary care sub-specialty center where we see such persons weekly on our monitoring unit, we are still occasionally "fooled" by the presentation of patients we are initially fairly confident (from history and description) will be nonepileptic, but who then turn out to have atypical epileptic seizures, or visa versa.

This paper sets forth information and guidelines for physicians who may be dealing with such difficult patients in the outpatient setting. If our practice at the CNI Epilepsy Center is a representative of the prevalence of such disorders as we suspect, each practitioner reading this article probably has patients with PNES who appear to be epileptic according to the details of their related histories — and of course, the converse is also encountered.

*Types of Nonepileptic (Psychogenic) Seizures.* Although there are non-psychogenic types of nonepileptic seizure phenomena and have been several proposed nosologies for the condition, (2) this paper is concerned entirely with the psychogenic variants seen in adults: **Conversion Disorder** — convulsive type, a more specifically **Dissociative Conversion** variation, a **Conditioned Response Syndrome** that takes a somewhat different form than the other two types, as well as **Atypical Panic States**. The single thread common to each is the absence of factitious or malingering etiology. In other words, these events occur experientially for the patient just as if they were neurologic

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seizures. For this reason, we avoid speaking of "pseudoseizures", which term inevitably conveys pejorative connotations. In fact, such events are unconsciously produced, are not under the volitional control of the person experiencing them, and are not passive-aggressive, manipulative attempts to control or fool others, either for gain or for attention and sympathy.

Nevertheless, although PNES are not produced consciously to manipulate, they not uncommonly develop and function so that they ultimately do. This is not always a bad thing. A not-infrequent form of such a phenomenon is the case of the abused woman whose husband stops mistreating her after she develops "seizures," with her attendant regular medical check-ups and scrutiny, etc. In such instances, my experience is that the patient's symptoms represent a kind of unconscious intelligent self-protection, a not uncommon strategy in people faced with severe life conflicts.

Each type of PNES disorder is a little different from the others, as regards to its etiology, its course, and its needed treatment.[3] In the following discussion, my attempt will be to be brief and practical, focusing the discussion on matters of clinical practice.

*Comorbidity.* The issue of comorbidity with true epilepsy is also highly controversial. Initial reports in the literature predating video-EEG telemetry sometimes suggested comorbidity rates as high as a third of seizure patients, and reports as high as 50 percent have at times been made. One recent paper carefully looking at this phenomenon in an American epilepsy center's PNES population (n=32), found about 10 percent had confirmed interictal epileptiform discharges.[4]

It is likely to be some time before clear population figures regarding this phenomenon can be advanced with confidence.

*Etiology and Course.* The hallmark PNES disorder is probably conversion disorder, convulsive type, in which the seizure symptom is commonly understood to represent some underlying psychological conflict, most often involving feelings of rage and helplessness. In our inpatient diagnostic series, this is probably the most common form of the PNES spectrum we encounter, although it may look quite different and unfold quite differently in each individual patient.

The vast majority of conversion disorder patients come to us with fairly complicated histories of psychosocial trauma and/or clear-cut sexual abuse. They were frequently prevented from defending themselves or securing protection from others, and an extremely common phenomenon in the clinic is their feeling that they are not being believed when they describe their current symptoms and condition. Being understood to have a "real" problem is of enormous importance to such patients, who may protest when presented with evidence that their symptoms are not of neurogenic origin, re-experiencing the moment of earlier disbelief by others when they complained of abuse or maltreatment and sought protection from it in childhood.

In our experience at CNI, such patients tend first to display PNES symptoms at a relatively early age, frequently in late teens or early adulthood. Frank dissociation is a frequent, but not inevitable phenomenon. Sometimes patients are aware and/or communicative during convulsive events, though most often they are not. It is also not terribly uncommon for patients with

conversion disorders to complain of tongue biting and incontinence (both urinary and fecal are sometimes reported), though these may be more intermittent than inevitable with PNES attacks. Once conversion symptoms develop, the course appears largely progressive without notable remissions, at least in the group of patients who reach our center for assistance. Onset of symptoms in such patients is often dramatic and sudden, and deeper probing of personal histories by psychological experts very frequently uncovers unambiguous traumatic events.

In many cases, such patients have been told by one or more physicians in the past they do not have epilepsy, and need to stop their PNES behaviors. Not infrequently, patients report that physicians seem angry with them, and accuse them of "doing this on purpose." Given the unconscious, defensive (protective) etiology for such symptoms, it is not surprising such confrontations are typically met with symptom intensification rather than remission.

*Dissociative variant.* The dissociative variant of conversion most often is seen in patients who have suffered either severe early childhood trauma, parental abuse, or relatively horrific adult trauma (torture, rape, etc.). In such cases, dissociation appears to have been the person's way to survive an "impossible situation." In essence what was perpetrated on their bodies was not in essence perpetrated on "them," and they physically escaped via dissociation during the moments of abuse. Dissociative patients frequently complain of "memory problems," which on neuropsychological inspection, often turn out to involve the selective loss of personal history and/or forgetting of autobiographical material, both exceedingly rare phenomena in neurological conditions. In addition, the majority of our series of dissociative patients will describe retreat into fantasy, depersonalization phenomena, and clear-cut "clicking off" from as far back as they can remember, especially when they are under stress or pressure.

*Conditioned response.* The conditioned response variant of conversion disorder is an interesting syndrome. In this condition, personal histories are not uncommonly absent specific and dramatic traumatic events. Instead, a pathological psychological *process* seems to be at the root of the disorder, in that these patients typically take care of everyone else's needs to their own detriment, even when it may appear ridiculous or outrageous to an outsider that they do so. They typically defer their own wants and needs and may not even recognize they have them. Such individuals often come across as (and indeed are) not so much weak as "hyper-strong." We frequently find them holding down several jobs, taking foster care of other dependents in addition to their own children, etc. They seem to be a subtype of individuals who are on the surface determinedly independent, competent, proud, strong, and appear to all intents and purposes the very opposite of "hysterical." Most astonishingly, perhaps, such patients typically do not consciously experience their lives as being particularly, or even at all, stressful, and often quite nonchalantly describe lives and situations that involve truly extraordinary, and sometimes unremitting, severe psychosocial stress. These persons seem to develop an almost classically conditioned PNES response to levels of stress, and black out, "click off," or experience convulsive shaking when stress of any sort exceeds a certain threshold level.

*Atypical panic reaction.* Finally, atypical panic reactions are sometimes mistaken by patients and physicians for seizure phenomena, as these may be accompanied by hyperventilation and syncope, paresthesias, and other autonomic phenomena, depersonalization, and changes in level and state of consciousness. In most cases, the shaking or trembling associated with intense anxiety and the preservation of clear consciousness and communicative capacity during events, makes diagnosis of this variant with telemetry fairly simple and straightforward.

The classically "hysterical" or histrionic patient is much less commonly encountered than might be expected in the PNES population. The great majority of our conversion patients are truly miserable with their symptoms, and wish terribly for them to remit or disappear. In the past 13 years, we have seen 10 or fewer such individuals among the hundreds and hundreds of PNES patients who have passed through our clinic and hospital doors. These are the individuals with true *la belle indifference*, and who not infrequently develop "symptom substitution" when the telemetry case against epilepsy has been convincingly made.

*Appropriate treatment.* While a detailed discussion of treatment for the many types of individuals described above is beyond the scope of this brief article, it is useful for physicians to understand what usually works and doesn't, as well as the kind of care required and faced by PNES patients to address their problems successfully.

Treatment begins with the delivery of diagnosis, and the manner of diagnosis delivery may literally determine outcome.

Direct confrontation or the inadvertent expression of anger about having been "fooled" by the patients' initial symptoms, which may have sounded very much like epilepsy, almost always works against both the doctor and the patient. An approach that acknowledges the patient's real misery with symptoms and relieves the patient of shame or guilt for having "caused" the problem is in order. It should be stressed that a diagnosis that excludes epileptic seizures is a positive fact that eliminates the fear of the significant morbidity and mortality of that condition. Also, now that it has been properly diagnosed, effective treatment is available and can be offered with an excellent chance of symptom resolution. Consult a psychologist expert in somatoform patient management if you have questions about the most effective approach in a given case.

Skilled psychological care, psychophysiological intervention as well as psychotherapy, is virtually always indicated. This care is notably different from simple "counseling", and involves a variety of possible interventions.

In most PNES disorders, assessment and treatment of autonomic hyperactivity via relaxation therapies, breathing or biofeedback techniques, meditation, and the like, is vital. In providing such treatment, it is essential to tailor the therapeutic approach to the personality style of the individual, as successful outcome turns on adherence. One person's helpful meditation may be another's sheer boredom, while for someone else, the use of biofeedback devices may feel sterile and obtrusive. The not infrequent emergence of frightening posttraumatic memories and panic during relaxation therapies needs to be monitored and treated immediately when it occurs. This is why simple "relaxation tapes" may be a problematic, or even dangerous approach at times.In some cases, psychotropic medications can play a useful adjunctive role

in treatment, though psychological meanings can be complex and problematic here. Patients sometimes feel they are being told their feelings in reaction to experienced traumas are bad or unacceptable when given pills to change them, so prescriptions must be done sensitively and with such potential issues set directly on the table. For example, "I am offering you something to make you feel better, but I don't want you to think I don't understand you have plenty of reason to be angry or sad about what happened to you."

Patients with histories of severe trauma require psychotherapy to work through destructive events and processes, and to integrate the memories of them into more resilient and reconstituted senses of self. Ongoing "body memories" seen in the somatic replay of the symptom or conflict can be transformed into cognitive ones. Expertise in trauma psychology should be rigorously established before undertaking psychotherapy with such persons. This is dicey therapy where technique matters greatly.

Family behavioral and other issues frequently need to be assessed and addressed clinically before patients with PNES can be helped. I have mentioned the example of the battered spouse above, but in more general and subtle terms, PNES can be inadvertently reinforced via a whole set of complex family interactions, the treatment of which sometimes results in dramatic symptom reduction.

Finally, hypnosis, when utilized by a skilled, well-trained medical or psychological practitioner, can often play a powerful role in the clinical intervention and care of such individuals, particularly those with dissociative disorders. Again, this is tricky and complicated work, and should be attempted only by experts in the area.

*Conclusion and recommendations.* In conclusion, I would like to summarize and suggest a few clinical ideas to keep in mind whenever you find yourself dealing in your practice with what looks as if it might be a conversion reaction or nonepileptic psychogenic seizure patient.

- *Might be, might not.* Only video EEG will tell this tale — there really are few PNES malingerers out there. Refer the patient somewhere for monitoring and find out for sure before moving in a particular direction for care.
- *Presume it's unconscious*, not consciously manipulative, and you'll be right the vast majority of the time. Treat patients with respect: their suffering is real, enormous, and experienced as wholly out of their control for good reasons.
- Remember that psychogenic patients present with widely varying characteristics: strong, weak, anxious, impervious, young, old, squirrelly, and straightforward, just like any other condition.
- There's not always a history of abusive trauma with such patients, but it's worth thinking twice about the possibility of PNES if there is.
- Psychotropic medications may be paradoxically frightening to such patients and they may get worse if you start them without establishing what the perceived or implied "meaning" of your prescription is.
- Stress" is in the eye of the beholder — patients maybe unaware of it in their lives and need help just learning to recognize it much less manage it.
- PNES and epilepsy can coexist. Presence of one never rules out the other. Patients sometimes develop PNES after successful epilepsy surgery.[5]
- Referral to psychotherapy or neuropsychology can always be framed

positively and supportively.

*"In suggesting this, I don't for a moment think you're crazy. No matter what's causing these attacks, they are miserable and disrupting your life. Let's get you to a doctor who can help you/your body learn ways to minimize their occurrence, and perhaps change the impact they are having on your life right now.*

*Address comments and questions to:*


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