THE MANAGEMENT OF NON-EPILEPTIC SEIZURES

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INTRODUCTION

- Concept of hysterical conversion
- Theoretical perspectives
- Clinical features of “non-epileptic seizures”
- Assessment and management of “non-epileptic seizures”

Hysterical conversion Psychodynamic/interpersonal models

- A reaction to environmental stress
- A means of gratification of dependency needs
- A form of communication

Reaction to environmental "stress"

- Self preservation (e.g. "war neurosis" of WW1)
- Response to frightening, life-threatening experience (e.g. "railway spine" of the 19th century)

- **Gratification of dependency needs**
- **Symptoms as communication**

Conversion Symptoms

- Applied to disturbances of motor or sensory function, arising in the absence of any demonstrable lesion of the relevant neurological pathways.
- Patients complain of:

  Failure of sensation (blindness, deafness, coetaneous sensations)

  Muscular weakness or paralysis

Conversion Symptoms cont

- By convention, the term is restricted to disturbances referable to somatic afferent or efferent pathways
- For historical reasons, convulsions are also included

Non-Epileptic Seizures

- “Pseudo seizures”
- “Psychogenic seizures”
- “Psychogenic non-epileptic seizures”
- “Non-epileptic attack disorders”
- “Functional seizures”

“Pseudo seizures”

- Later onset than epilepsy, more common in females
- Bizarre in pattern
- Vary from one occasion to another and particularly expressive
- Onset gradual, duration can be extended

“Pseudo seizures” cont

- Movements often have organized pattern - may involve out-of-phase clonic movements, forward pelvic thrusting, or side-to-side head movements
- Typical tonic-clonic phase usually absent
- May increase in intensity if restraint is imposed
- Usually terminate without evidence of post-ictal confusion, stupor or sleep

"Pseudo seizures" cont

- Rarely associated with incontinence or self-injury
- Tend to occur in response to emotional precipitants, rarely occur when alone
- Consciousness often retained, rarely occur during sleep
- The prodrome variable, sometimes with anxiety and overbreathing

Examination Findings

- No cyanosis, pallor
- Normal pupillary reflexes
- Normal deep tendon reflexes
- Negative Babinski sign
- Memory of seizure may be present
- Orientation (T, P, P) is often normal post-seizure
- Post-seizure headache or pain is rare
- "La belle indifference" may be present

Investigations

- EEG – seizure and inter-seizure
- Prolonged EEG /Video monitoring
- Prolactin level

Detailed History

- Past medical history
- Past psychiatric history
  - History of conversion symptoms
  - Other neurotic symptoms, e.g. anxiety, depression, obsessions, phobias, sexual dysfunction
  - Attempted suicide or self-harm
- Family history
  - Psychiatric illness
  - Seizure disorder

Detailed history cont

- Current psychosocial stressors, personal circumstances
- Recent losses, disruption of key relationships
- Personality style/function
- Presence of mood disorder
- Use of medication, illicit substances

Differential Diagnosis

- Acute anxiety state
- Schizophrenia (with TLE type symptoms)
- Factitious disorder
- Malingering

Differentiation conversion, factitious disorder, malingering

	Choice of Symptoms	Motivation
Conversion	No	Unconscious
Factitious Disorder	Yes	Unconscious
Malingering	Yes	Yes

Management

- Thorough clinical assessment
- Clarification of history – predisposing and precipitating factors
- Exclude psychiatric illness
- Investigations - to exclude organic pathology
- Psychological intervention (neurologist/psychiatrist)

Psychological intervention

General

- Establish rapport
- Reassure that recovery will not be long delayed
- Avoid diagnostic labels
- Acknowledge significance of symptoms, and associated distress
- Offer some form of rationale for symptoms (explanatory model)

  e.g. mind/body interaction, stress response

Psychological intervention cont

General

- Reassure that epilepsy is not the problem, and that the brain does function normally
- Avoid reinforcement of invalidity
- Avoid further medicalization of the problem (through more investigations, specialist opinions)
- Be selective with medication (particularly with pre-existing epilepsy)

Psychological intervention cont

Specific

- Assume that patient's motives are unconscious
- Explore possible causal factors (current and past)
- Seek understanding of the neurotic, psychodynamic and communicative aspects of symptoms, and the secondary gains that might be relevant

Psychological intervention cont

Specific

- Suggest alternative stress responses, coping strategies
- Manipulate environment, where possible (working with family, key people)
- Try to minimize chronicity of symptoms, entrenchment in the sick role

Psychological intervention cont

- Intervention will be influenced by patient's personality structure
- Supportive psychotherapy is the mainstay of treatment
- In-depth psychotherapy helpful for a small number

Psychological intervention cont

- Keep in mind the old aphorism:

  "the hysteric is an actress who has become so convinced by her own performance that she has joined her audience!"

Prognosis

- Need for caution in diagnosis of conversion disorder
- Slater (1965) : 60% diagnosed with conversion hysteria developed diagnosable neurological illness in next 10 years
- Mace & Trimble (1996): 15% had established neurological diagnosis 10 years later.

  NB: Only 3% had relief of original symptoms

  ie. prognosis for recovery is poor

Prognosis cont

- Stone et al (2005):

  27 studies including 1,466 patients, median follow-up 5 years

  Significant decline mean rate of misdiagnosis from 1950's to present day – 29% in 1950's to 4% in 1990's

  Decline independent of age, sex, duration of symptoms.