Evidence-based hypnotherapy for Psychogenic Non-Epileptic Seizures

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Psychogenic Non-Epileptic Seizures or *PNES* are paroxysmal episodes of altered movement, sensation, or experience resembling epileptic seizures, but not associated with ictal electrical discharges in the brain.

League Against Epilepsy Annual Report, 2015

PNES are …

- *… frequent: from 12 to 18% of referrals to neurology clinics*
- *… commonly misdiagnosed: 5.6 years of diagnostic delay (DS 7.7)*
- *… treated inappropriately: approximately three fourths of patients receive AED treatment before their diagnosis*
- *… severe: two out of three patients need to be hospitalized in the first year of disease*
- *… 'serial patients': two thirds of patients drop out the treatments*
- *… comorbid with epilepsy: 25% of epileptic patients have PNES*
- *… a psychological syndrome: psychopathology is more florid and severe than other Functional Neurological Disorders subtypes*
- *… potentially chronic and disabling: less than 25% of spontaneous recovery, frequent relapses, low quality of life, high healthcare costs*

Evidence.

- Dissociation is a common trait in PNES, much more than other FND (Goldstein, 2000; Brown *et al.*, 2006; Vuilleumier *et al.*, 2014).

- Abnormal functional connectivity has been found in PNES between emotional processing network and executive motor control network (van der Kruijs *et al.*, 2012; Barzegaran *et al.*, 2015).

- Both epileptic and PNES patients are able to identify emotions but are lacking in coping strategies for emotional regulation (Urbanek, 2014).

- Both epileptic and PNES semiology can be due to a temporary loss of executive control that facilitate stereotyped patterns (the 'Carillon theory') (Tassinari, 2006).

- PNES patients are highly hypnotizable (Hulble, 2012; Cardeña, 2003; Wolf & Brown, 2002)

MARGINALIZATION

The process of structuring and enforcing
the self-experience of interaction.

Emerging Self

Individualization ⟷ Normalization

Interacting Self

The process of adapting and responding to
the perceived other's experience of interaction.

INTEGRATION

SOMATIC RESIDUE (SEIZURE)

The process of disengaging and desensitization
of the executive control of the brain.

Functional Disconnection

Detachment ⟷ Normalization

Interacting Self

The process of adapting and responding to
the perceived other's experience of interaction.

INTEGRATION

An Ecological working hypothesis

Functional Somatic Symptoms are the bodily counterparts of unprocessed emotions.

Avoiding a part of emotional experience is an adaptive strategy to social environment.

An Ecological working hypothesis

1) To process avoided emotions

2) To re-structure hyper-adaptative strategies

An Ecological working hypothesis

Introspection

Self-control through *self-awareness*

Felt-sense (Gendling, 1996)

Step One. Cooperative and affirmative context

Interdisciplinary diagnostic assessment

Emphatic and honest explanation

Psychosocial exploration

Outcome indicators

Tailor the explanation of the diagnosis to give to the individual patient, avoid general reference to 'stress' and figure out his own situation.

Be **non-offensive, transparent, logic, clear** and do not concern sharing uncertainty and doubts with the patient,

Prefer the word '**functional**' to describe the nature of the symptoms, since it helps to introduce the psychological issue of the problem, and avoid any reference to the 'physiological vs psychological' dichotomy.

Point out that the symptoms are **genuine neurological symptoms** but they are not due to a degenerative or structural brain disease therefore they can improve and recover; if needed, directly demonstrate the patients' diagnostic clinical signs or showing to them neuroimaging and other instrumental studies.

Provide a rationale about the **available treatments**, focusing on the importance of the collaboration of professionals from different fields (psychiatrist, psychologist, neurologist, physiotherapist, etc.)

Emphatic and honest explanation

Outcome indicators

Clear motivation

Strong felt-sense

Feelings of incoherence and doubt (somatic persecutor)

Ongoing acute experience

Step Two. Hypnotic Neuromodulation

Identify the stereotypy with psychological consistency

Pace the phenomenology

Focus on sensory memory of interaction

Identify the stereotypy with psychological consistency

Instruct caregivers to record and describe seizures

Collect and analyze patient's accounts *(predictive of the nature of seizures, Reuber, 2003, 2011)*

Clinical Features

1. Ictal course
2. Motor manifestation
3. Sensory manifestation
4. Autonomic manifestation
5. Affective manifestation
6. Vocalization
7. Facial features
8. Injuries
9. Post-ictal course

Semeiological classification

Class 1 – dystonic attacks with primitive gestural activities

Class 2 – paucikinetic attacks with or without preserved responsiveness

Class 3 – pseudosyncope with or without hyperventilation

Class 4 – hyperkinetic prolonged attacks with hyperventilation, involvement of limbs and/or trunk

Class 5 – axial dystonic attacks

Class 6 – unclassified type

Table 2 Main semiological characteristics of the five clinical subtypes of psychogenic non-epileptic seizures

Class 1 (31.6%) Dystonic attacks with primitive gestural activity	► Short seizures: less than 5 min (100%) among which 61.5% are between 1 and 5 min ► Generalised to the four limbs and sparing the trunk in 66.7% of cases, ► Dystonic movements (of upper (71.8%) and lower limbs (59%)) ► Oro-alimentary movements (43.6%) ► Primitive gestural activity (48.7%)
Class 2 (23.4%) Pauci-kinetic attacks with preserved reponsiveness	► Gradual onset and end ► Movements of low amplitude: fine and often focal tremor (localised to a limb or the head in 51.7% of cases and halfbody in 6.9% of cases). ► Preserved responsiveness in 96.6% of seizures ► Sensory manifestations in 34.5% of seizures
Class 3 (16.9%) Pseudosyncope	► Short seizures (66.7% of seizures less than 1 min and 100% less than 5 min) ► Abrupt onset (76.2) and end (95.2%) ► Unresponsiveness (85.7%) ► Closed eyes (71.4%) ► Motionless axis (100%) ► 'Myoclonus' (52.1%) ► Often silent (95.2%)
Class 4 (11.7%) Hyperkinetic prolonged attacks	► Prolonged seizures (80% of more than 5 min) ► Gradual onset and end (80%) ► Auras (66.7%) ► Varied movements: dystonic (60% lower and 40% upper members), rotation of the head (46.7%), tremor (60%) ► Unilateral rotation of the head (46.7%) ► Hyperventilation (73.3%) ► Fluctuating intensity of symptoms (80%)
Class 5 (16.4%) Axial dystonic prolonged attacks	► More than 1 min (95%) ► Gradual onset and end (75%) ► Generalised ► Dystonics movements (upper (80%) and lower limbs (95%)) ► Axial extension (85%) including opisthotonos ► Fluctuating intensity of symptoms (85%) ► Vocalisation (wailing, 85%), hyperventilation (75%)

From Hubsch et al, J Neurol Neurosurg Psychiatry 2011; 82:955-960

Focus on sensory memory of interaction

Sensory memory of relation is the primitive, stable and embodied component of memory on which the development of attachment and emotional regulation relies on.

Hypnotic regression is not a temporal but a perceptive regression.

Step Three. Emotional Regulation

Enhance interpersonal emotional awareness

Decrease interactive emotional incoherence

Desensitize recourse to dissociation and elicit integration