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Psycho- Social Stressors and Pseudoseizure – A Case Report

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Abstract: *Psychogenic non-epileptic seizures (PNES), also known as pseudoseizures are events superficially resembling an epileptic seizure, but without the characteristic electrical discharges associated with epilepsy. Psychogenic nonepileptic seizures are paroxysmal episodes that resemble and are often misdiagnosed as epileptic seizure. PNES are triggered by psychological problems and it is estimated that 20% of seizure patients seen at specialist epilepsy clinics have PNES . The prevalence of psychogenic non-epileptic seizures is somewhere between 1/50 000 and 1/3000, or 2 to 33 per 100 000, making it a significant neurologic condition. In a community survey of rural India, the prevalence of pseudoseizures has been found to be 2.9 per 1,000 population. Most PNES patients (75%) are women, with onset in the late teens to early twenties being typical researchers postulating that PNES may be an expression of repressed psychological harm in response to trauma such as child abuse, bullying in adulthood, sexual abuse or adverse family dynamics. Pseudoseizures must be correctly recognized because a misdiagnosis can be harmful. The management of pseudoseizures requires good psychoeducation to the patient and family regarding the causes, symptom manifestation, course and outcome. Therapies focusing on offering support, improving coping patterns and problem solving skills of the client are beneficial.*

Keywords: *pseudoseizure, PNES, epilepsy, psychoeducation.*

I. Introduction

Psychogenic non-epileptic seizures (PNES), also known as Non-Epileptic Attack Disorders, are events superficially resembling an epileptic seizure, but without the characteristic electrical discharges associated with epilepsy. Thus, PNES are regarded psychological in origin, and may be thought of as similar to conversion disorder. The prevalence of epilepsy is 0.5% to 1% in the general population; among the general population, intractable epilepsy accounts for 20% to 30%, of which 10%–20% is accounted for by PNES [1]

The term pseudoseizure most often refers to non-epileptic seizure-like events not accompanied by acute cerebral dysfunction or by paroxysmal epileptiform electrical activity. Usually, pseudoseizures are thought to represent psychiatric disease, especially if a physiological etiology has been thoroughly excluded and the relevant psychopathology demonstrated [2] Psychogenic non-epileptic seizures (PNES), also known as non-epileptic attack disorder are events that apparently simulate an epileptic seizure and are triggered essentially by emotion and psychological events of which a patient does not have control [1]

Psychogenic non-epileptic seizure (PNES) can also cause a sudden change in a person's behaviour, perception, thinking, or feeling that is usually time limited and resembles or is mistaken for epilepsy, but does not have the characteristic electroencephalographic (EEG) changes that accompanies a true epileptic seizure. It is considered that PNES is a somatic manifestation of mental distress in response to a psychological conflict or other stressors.

Pseudo-seizure represents the opposite end of the spectrum from seizures that mimic psychiatric disorders. Accurately distinguishing pseudo-seizure from epilepsy and other illnesses is difficult because of the breadth and overlap of symptoms seen in each condition and because of the frequent co-occurrence of pseudoseizure and epilepsy [3].

II. Method

Case Report

A 17 year old unmarried female, 11th standard student presented with left sided chest pain of 25 days duration. Ten days later she started behaving abnormally. She was abusive, throwing things randomly, suspicious about being getting killed. Many a times, patient became unconscious intermittently, without having any tonic clonic contraction of limbs, had no evidence of frothing, tongue bite and incontinence of urine and

stool. Patient remained unconscious for 3-4 hours; there were multiple episodes occurring in a day, though she could understand verbal commands. Subsequently the patient became mute. Patient was brought to the Out Patient Department of a neuro- psychiatric hospital, the Institute of Human Behaviour and Allied Sciences Delhi.

The patient was evaluated by the Neurologist and on examination; there was no evidence of any neurological deficits. Her routine investigations including complete blood count, blood sugar, renal and liver function tests, serum calcium, EEG, ECG and MRI brain were normal. Subsequently the patient was referred to Psychiatric Social Worker for psychosocial intervention. The patient was assessed by Psychiatric Social Worker, where a detailed assessment was carried out to explore the possible psycho social stressors so that appropriate interventions could be planned. A total of 7 sessions were conducted with the patient and the family members, which are detailed below, session–wise. All these sessions were carried out at the Out Patient Department basis.

III. Process Of Psychosocial Intervention

Session I

The first session was conducted with the patient and parents separately. During this time detailed history was taken. In the beginning, the patient was uncooperative and also unwilling to attend the session. It was difficult to establish rapport with her.

Session II

In the second session conducted, the patient was allowed to ventilate and express herself and share her feelings and distress. It took some time for the therapist to establish rapport with her. Slowly and gently, the stressors were explored. It was found that, patient had initiated an affair with a boy; but upon knowing this, her parents had become furious with her. They had warned her against this relationship as they said they would never accept this boy. When the patient did not budge, she was subjected to physical torture by the father, wherein he used to beat her badly and threaten her of dire consequences if she continued the relationship. She was given strict instructions to break the relationship and not allowed to go out. Session with the parents revealed that during all this time, patient had had episodes resembling a seizure with no frothing, and these episodes were predominantly seen when there were severe arguments between her parents and her. They also reported that since the time she was compelled to remain in the house, the patient became mute and started communicating by gestures only.

Session III

In this session, the patient was allowed to ventilate. She shared her helplessness and feelings of despair with the therapist. Supportive couselling sessions were initiated [4] and she was also provided with necessary psychoeducation about the nature of illness which was mainly psychological in nature. Family was also given the psychoeducation and was explained about the patient's nature of illness, symptoms, cause and prognosis.

Session IV

In this session, the patient was counselled regarding her ongoing stressors. She was explained the healthy coping mechanisms to deal with the stressors which were mainly in the form of seeking support and sharing her emotions and feelings openly. She was educated about the various kinds of problem focused coping and explained about how using avoidance as coping was detrimental to her mental health. Her parents were also counselled regarding their role as caring parents, which is highly required for dealing with such situation. With adequate support and non-blaming attitude used by the therapist, the parents gradually acknowledged the need for love and care by the patient. They also assured the therapist that they would correct themselves. Because family issues are often important contributing factors, it was considered important to involve family members in the therapy with consent of the patient [4]. By the end of the fourth session, the patient started communicating by gestures as well as through writing.

Session V

This session was conducted exclusively with the patient; she was comfortable and frank in the session. She started communicating better than earlier and could share her emotions easily. The patient showed increased confidence and comfort in handling the situations. She was further counseled and was appreciated for her efforts.

Session VI

Sixth session was conducted with her parents and they were asked about the improvement observed by them in the patient. Their apprehension regarding prognosis of the illness, marriage related issues were taken up.

Parents were again counselled regarding their role, and need for constant encouragement, providing the much needed love and affection and emotional support.

Session VII

This session was conducted with patient and parents jointly. The current status and level of improvements were reviewed and discussed other relevant issues. The counseling session was focused on creating a conducive environment at home and facilitating in maintaining harmonious relationship amongst the family members. The patient was also suggested to continue her education and regular follow up sessions with the therapist was emphasized. The therapist emphasized as good news the fact that the patient did not have epilepsy, and stressed that the disorder, although serious and "real," did not require treatment with antiepileptic medications and that once stress or emotional issues were resolved, the patient had the potential to gain better control of these events [5].

The patient followed up with the therapist regularly for nearly two years wherein the sessions focused on enhancing her problem solving abilities, adopting healthy coping mechanisms in times of need, expressing and sharing her concerns and difficulties with near and dear ones, evaluating every difficult situation after duly appraising the merits and demerits of the same and taking well thought out decisions pertaining to her life. Studies report that patients who continue to be followed by the treating therapist or center do better than patients who are not seen after diagnosis [6] [7].

IV. Discussion

Pseudoseizure is also known as hysterical seizures, hysterical epilepsy or reactions and they clearly resemble epileptic attacks. Pseudoseizure is psychogenic illness lacking the abnormal paroxysmal electrical discharges from the brain [8].

Nonepileptic seizures or nonepileptic events are broader terms meant to incorporate both physiologic and psychological causes for disorders that are mistaken for epilepsy. PNES are widely defined as paroxysmal events that appear similar to epileptic seizures but are not due to abnormal electrical discharges in the brain and as noted, are typically thought to be related or caused by conversion, somatization, or dissociative disorders [5].

Psychogenic based treatment of pseudoseizure is mainly depending upon psychosocial interventions based on counseling and supportive psychotherapy. Once the diagnosis of pseudoseizure is established, the patient usually is sent for counselling. Counselling is extremely helpful as it not only addresses the current problem but also improves the course and prognosis of the problem.

Conversion disorder is thought to be associated with psychological factors because of the presence of conflict and other stressors prior to the condition [9]. Nonepileptic seizures have become the focus of clinical and research attention and it is reported that the majority of the pseudo seizure patients were female subjects. Severe environmental stress, history of physical and sexual abuse and traumatic experience are common among children and adolescents with nonepileptic seizures [10] [11].

The most important aspect of treating pseudoseizure is treating the factors which cause them to occur. Learning to be aware of and control emotions, adopting healthy coping mechanism to deal with ongoing stressors, tolerate anxiety, and communicate effectively regarding one's needs and desire which is crucial to mental health. Pseudo seizure is associated with a significant burden for the child, family, and the health system. Their co-morbidity with anxiety, depression, and symptoms of pain and fatigue are well known [12]. Adoption of the sick role and environmental reinforcing factors are more relevant in chronic pseudoseizures [13].

Pseudoseizures are little more than coping mechanisms which are employed, which are indeed faulty; because effective strategies for coping and responding to upsetting situations are not in place. It is important that people, including medical and mental health professionals, learn about pseudoseizures, their cause and treatment. Daily life for someone with pseudoseizures can be improved dramatically if the therapist knows how to treat the underlying cause effectively. Treatment is most successful when the person is encouraged to explore his/her feelings and assisted in learning to cope with the feelings in new ways [14]. Continued sessions with the patient help in reducing the symptoms and to adopt better coping mechanism. Psychotherapy or feedback provided by CEP professionals with experience in epilepsy and PNES improves outcome and may be superior to other or no interventions [6].

In the current case, ongoing stressors were found to be one of the reasons for pseudoseizures and with counseling sessions, the patient was helped to understand her problem, make some healthy coping strategies. Psychotherapy was given to overcome the stressors. Pseudoseizures or psychogenic non-epileptic seizures (PNES) are often misdiagnosed as epilepsy.

The prognosis for the majority of patients with PNES appears to be poor, despite a wider recognition of the problem. Well conducted studies are needed to test the different treatment options. [15]). Poor prognosis is related to chronicity and complex psychological and psychiatric problems [16]. Young patients may require only relatively simple measures to lower stress levels, thereby reducing their attacks. Causes lying external to the

patients are more susceptible to recognition and hence intervention than predicaments arising in adults whose long history and entrenched maladaptive behaviour is difficult to modify.

V. Conclusion

Adolescent age group is most vulnerable for getting Pseudoseizure, which needs to be looked into from a different perspective without blaming the group. Mental health professionals need to prepare not only these groups to handle with such situation, but also to educate their parents for their better tomorrow. Pseudoseizures are often difficult to differentiate because there are client based or clinician based factors leading to misdiagnosis. The correct diagnosis of pseudoseizure can help avoid unnecessary physical tests and prescription of antiepileptic drugs [17]. Detailed history, observation, psychological testing and laboratory investigations are used for correct diagnosis. Management consists of making the patient and relatives aware about the causation and diagnosis. Professionals with experience in both epilepsy and psychogenic non epileptic seizures are better managers of treatment and care of such patients presenting with pseudoseizures.

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