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Perspective

Dissociative seizures - A critical review and perspective

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ABSTRACT

Dissociative seizures are commonly recognized as both a challenging and a poorly understood condition. Though research and publication activity is high, advances in knowledge and insight seem only moderate in recent years. This review focuses on some relevant problematic issues, which might account for a still unsatisfactory research state. A general tendency to deal with dissociative seizures as an assumed disorder in its own nosological right and not as a sole symptom of an underlying psychiatric disorder is most likely one of the major roots of the problem. Unfavorable impacts of this confusion pertaining to clinical management, therapy, and outcome of dissociative seizures are discussed. An alternative point of view, based on the immanent psychiatric and psychodynamic roots of dissociative seizures, is considered.

1. Introduction

In the field of psychogenic nonepileptic seizures (as dissociative seizures often are referred to), quite an impressive number of research papers and reviews have been published in the last two decades. However, a critical synopsis reveals that gains in knowledge and insight are rather moderate. The summaries and conclusions often are repeating covered ground and, therefore, redundant: Dissociative seizures are recognized as a very challenging disorder causing high sociomedical costs. Differential diagnosis remains difficult. Etiology and pathogenesis are globally assigned to the psychological realm, though the associated mechanisms are regarded as poorly understood thus far. Neurobiological correlates or valid biomarkers are not yet established. Clinical management is appraised as difficult and rife with pitfalls, while therapeutic options are perceived as unsatisfactory, particularly because of the lack of evidence-based and seizure-specific psychotherapeutic programs. Short-term outcome and long-term outcome are poor, with the findings related to risk factors being inconsistent.

What are the reasons for these only moderate advances in recent years in the field of dissociative seizure research? The review presented here does not intend to give a comprehensive summary of the large body of research literature. This deserving task has been addressed in the course of the last two decades by quite a number of extensive reviews (both recently, e.g., [1–8], and in the past, e.g., [9–12]). Instead of adding another synopsis, I prefer to discuss and to comment on a number of problematic issues, which might have contributed to the unsatisfactory state of knowledge and insight. The covered topics include the precarious position of dissociative seizures between neurology and psychiatry, the question of terminology, the nosological affiliation, some selected aspects of the clinical management (like seizure induction for diagnostic purposes, countertransference, and disclosing of diagnostic findings), and, finally, some aspects of therapy and outcome research. I will argue that a general tendency to deal with dissociative seizures as a disorder (or a morbus) and not as a sole symptom might explain some of the obstacles to be overcome with a view to better understanding and research.

2. Dissociative seizures — a neurologic matter?

Among authors and researchers in the area, specialists from neurology or epileptology constitute the predominant majority. This is not surprising in that these medical faculties – nolens volens – are constantly challenged by the task to differentiate between epileptic and dissociative seizures. Their high research and publication activity includes issues far beyond differential diagnosis like etiology, treatment, and prognosis. The contrast to the extensive inactivity from the psychiatric side is rather sharp. Not only dissociative seizures but also the whole group of conversion symptoms or psychogenic symptoms (as they are often referred to) is rarely addressed by genuine psychiatric research papers. An inspection of the 2012 and the 2013 annual meeting program of the American Psychiatric Association (APA) may serve as an illustration [13,14]. The APA 2012 annual meeting comprised several hundreds of sessions and events. Just one workshop addressed the topic of conversion disorders; additionally, two minor symposia dealt with somatoform disorders. In the program of the 2013 annual meeting, the keywords “conversion”, “psychogenic”, and “somatoform” do not appear. One scientific report deals with “dissociative disorders and epilepsy”, whereas one neuropsychiatric symposium includes a presentation on “non-epileptiform seizures”. Compared to the frequently covered (and, most certainly, pharmacoeconomically much more interesting) mainstream themes like mood disorders or psychosis, conversion and somatoform disorders

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definitely rank on the very bottom of the hot topic list of current psychiatry.

"The problem of psychogenic symptoms: Is the psychiatric community in denial?" The question, Benbadis [15] posed eight years ago provocatively but rightly so, is still to be answered with a clear affirmative. Empirical findings as well as clinical experience point to an ongoing disregard of the psychiatric mainstream – willful or not – pertaining to dissociative seizures and other conversion symptoms. The reasons are manifold and may be found in two major fields.

2.1. Impoverishment of psychiatric theory

First, the turn toward a more descriptive psychiatric nosology was associated with the removal of the concept of neurosis from the major diagnostic manuals of mental disorders (the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA) and the International Classification of Disease (ICD) of the World Health Organization (WHO)). Among others, one of the main promoting arguments was the intention to boost interrater reliability. This is not the place for an appraisal of this claim. Howsoever, the preferred descriptive approach has obviously led to an impoverishment of theory and treatment know-how that fall far short of providing sufficient tools for understanding and treating the former hysteric and present conversion disorders. To clarify this point, let us have a short look into the rich archives of psychosomatic writings from the 1960s and 70s. As one example among many others, Engel [16] provides excellent clinical descriptions of patients suffering from monosymptomatic conversion disorder with their symptom and the so-called belle indifference as sole signs of severe neurotic morbidity. Such patients have not disappeared since that time. They are still and quite often seen in current neurologic or orthopedic consultations. However, reports of psychiatric consultants brought in for further clarification regularly and rather wonderingly state the lack of depression, anxiety, or other psychopathology that could give reasons for treatment. Conversion symptoms and the frequently underlying severe neurotic morbidity are no longer fully acknowledged by current psychiatry as a genuine psychiatric disorder requiring genuine psychiatric treatment.

2.2. Psychiatric reservations

Second, the psychiatric community seems to suffer from what psychoanalysis would call a countertransference problem. Many epilepsy centers (including the one in Zurich, Switzerland where I work) report significant difficulties in finding practicing psychiatrists or psychologists ready to undertake outpatient treatment of patients with dissociative seizures. As is well known, most therapies are working essentially by verbal interaction. In contrast, a dissociative seizure usually comes along with a strong bodily impact. We might speculate that the potential intrusion of so much physicalness evokes reluctance or even fear in many therapists. The impending seizure threatens to impede the order of verbal communication, and its unforeseeable course (for example, a prolonged loss of consciousness) could disturb the timetable of consultation hours. Furthermore, the confidence of mental health professionals pertaining to the diagnostic certainty provided by ictal EEG-video registration is rather low [17]. By contrast, neurologists express high confidence in the diagnostic validity of ictal EEG-video registration. This gap between differential diagnostic specialists and treatment specialists is remarkable, the more so as empirical findings since the 1970s clearly demonstrate a constantly low rate of only 4% of misdiagnosis in the field of conversion symptoms [18]. From a psychodynamic point of view, denial is one of the involved defense mechanisms operating in conversion symptom formation. An inner or social conflict is denied and replaced by an assumed diagnostic problem on the side of the neurologic specialists. Whatever the reasons may be, mental health professionals are inclined to act in the same way as patients do in this last-mentioned aspect. Little imagination is needed to predict the course of therapy, when a skeptical, more or less ambivalent patient meets a therapist mistrusting the validity of the seizure diagnosis for his or her part as well.

However, Benbadis' philippic [15] applies not only to the psychiatric community but also to the neurologic community, though the points of criticism are different, and the adopted defense mechanism, so to speak, is rather dissociation than denial. In what follows, some of the main issues usually addressed in current research papers and reviews with mainly neurologic backgrounds are focused on and critically discussed.

3. Terminology

"Psychogenic nonepileptic seizure" (PNES) seems to emerge in current literature as consensus regarding the appropriate diagnostic term. The scientific discussion about the proper naming of dissociative or conversion seizures is as extensive as it is actually strange (e.g., [19] or recently [20–24]). To the best of my knowledge, there is no other psychiatric symptom about which the naming is debated in such a controversial way. It seems that the void left over by the disposal of hysteria is not that easy to refill. Anyway, the term "psychogenic nonepileptic seizure" is at least a vast improvement on all the misnomers in use (from "pseudoseizures" to "nonepileptic seizures of nonorganic origin"). Though not very elegant, the term is certainly accurate. According to the neurologic point of view, epilepsy is set as reference, thereby focusing on the main differentiation between epileptic and nonepileptic seizures, with the psychogenic seizures forming a subgroup of the nonepileptic seizures. If dissociative seizures are considered as a "significant neurologic condition", as Benbadis and Hauser [25] astonishingly suggest, a consistent neurologic classification like "psychogenic nonepileptic" might be appropriate. However, if we agree that dissociative seizures represent a psychiatric symptom (as most researchers, at least since Charcot, do), why do we continue to use sophisticated linguistic constructs focusing on what is *not* meant instead of simply calling them according to their naming in the official psychiatric classification systems? The ICD-10 [26] uses the term "dissociative convulsions" as a symptom of a dissociative or conversion disorder, thereby acknowledging the mechanism of dissociation as pivotal in the formation of these symptoms (e.g., [27–29]). The ICD-10-CM (clinical modification, by the US National Center for Health Statistics, NCHS) [30] and the DSM-IV-R [31] prefer the term "conversion disorder with seizures or convulsions". The term "convulsion" is obviously restricted to motor phenomena, whereas the term "seizure" implies a broader meaning including, for instance, paroxysmal alterations in consciousness as well. The difference here between ICD-10, ICD-10-CM, and DSM-IV-R is of minor significance. The US-American DSM subsumes conversion disorders under somatoform disorders, acknowledging the dominant role of body involvement. The more consciousness-related dissociative disorders are listed separately. Conversely, the WHO classification considers conversion disorders as part of the dissociative disorders, assuming in both disorders an operant dissociative mechanism. Somatoform and psychogenic pain disorders are listed separately instead. The pros and cons of the two classifications shall not be discussed here. I would rather emphasize that "dissociative seizures" and "conversion disorder with seizures" are both appropriate psychiatric terms for this psychiatric symptom.

The question of terminology is not at all trivial as it might seem. The use of the term "psychogenic nonepileptic seizures" or similar constructs implies some major problems.

3.1. Dissociative seizures — a symptom or a morbus?

The prevalent research practice considers patients with dissociative seizures as a diagnostically homogeneous sample that is explored pertaining to common etiology, course, and prognosis. Implicitly, it is assumed that these patients constitute a disease or disorder group in the sense of a nosological group (i.e., morbus) in its own right. However,