



Psychogenic nonepileptic seizures: Characterization of two distinct patient profiles on the basis of trauma history

C. Hingray^{a,b,c,d,*}, L. Maillard^{b,e}, C. Hubsch^b, J.-P. Vignal^{b,e}, F. Bourgognon^d, V. Laprevote^{a,f}, J. Lerond^f, H. Vespignani^{b,d,e}, R. Schwan^{a,d,f}

^a CSAPA (Health Care Centre of Accompaniment and Prevention in Addictology), University Hospital of Nancy, Nancy, France

^b Department of Neurology, Central Hospital of Nancy, Nancy, France

^c Department of Medecine L, University Hospital of Nancy, Nancy, France

^d Faculty of Medicine, Nancy-University, Vandoeuvre-lès-Nancy, France

^e CRAN, UMR7039, CNRS, Nancy University, Nancy, France

^f CIC Inserm 9501, University Hospital of Nancy, Nancy, France

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ABSTRACT

This prospective study investigated and compared psychiatric features of 25 consecutive patients with psychogenic nonepileptic seizures (PNES) on the basis of presence of reported trauma. The “trauma” group comprised 19 patients (76%) and the “no-trauma” group comprised 6 patients (34%). We compared history of PNES, psychiatric comorbidity, alexithymia, and symptoms of dissociation. The study clearly characterized two distinct profiles of patients with PNES on the basis of trauma history. Patients with trauma had at least one psychiatric comorbidity or antecedent (vs 0% in the no-trauma group NT, $P < 0.001$) and a higher median score of dissociation ($P < 0.001$). Patients without trauma had more frequent “frustration situations” as a factor triggering PNES and subsequent sick leaves as perpetuating factors ($P = 0.001$). Trauma antecedents correlated with a high rate of psychiatric comorbidity and a strong dissociative mechanism. Patients without trauma had no psychiatric comorbidity and a weaker dissociative mechanism.

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1. Introduction

A psychogenic nonepileptic seizure (PNES) is a paroxysmal behavioral change that resembles an epileptic seizure but is not associated with electrographic ictal discharges. It is hypothesized to be caused by a “psychological process” [1]. Patients with PNES are often misdiagnosed with intractable epilepsy, and are thus potentially exposed to unnecessary anticonvulsant medications with iatrogenic consequences and socioeconomic costs [2]. Video/EEG monitoring is widely considered to be the gold standard for diagnosing PNES [3]. Approximately 25–30% of patients referred to epilepsy centers for refractory epilepsy are diagnosed with PNES [1]. Prevalence estimates range from 2 to 33 per 100,000 [4]. PNES occur mainly in young adults (second and third decades) and in women (75%) [1,5].

Psychiatric comorbidities and psychological and neurological factors contribute to the multifactorial nature of PNES [5,6]. The prevalence of psychiatric comorbidities seems to be at least 70% [7]. Alexithymia and impaired emotional processing are thought to be involved in PNES [8]. A high level of dissociation is also generally considered to be a mechanism underlying the development of PNES [9,10].

Numerous studies have also emphasized the high prevalence of trauma, with lifetime rates of physical and/or sexual abuse ranging from 50 to 77% [11]. Studies of correlations between trauma, biography, and PNES clinical characteristics have shown that trauma appears to be a less important etiological factor in subgroups of patients, such as men, persons with onset in late adulthood, and those with learning difficulties [5,12,13]. According to one study, patients with PNES with a history of sexual abuse were more likely to exhibit more severe signs such as urinary incontinence and self-injury and were more psychologically unwell [14]. Altogether, these studies suggest that trauma antecedent could be a distinctive feature. However, an understanding of the psychopathological mechanisms relating trauma antecedent to PNES requires further investigation.

In this study, our aim was to prospectively assess and compare psychiatric comorbidity, alexithymia, and dissociation in patients with

* Corresponding author at: CSAPA (Health Care Centre of Accompaniment and Prevention in Addictology), University Hospital of Nancy, 22 bis rue de Malzéville, 54000 Nancy, France. Fax: +33 3 83 32 45 05.

E-mail addresses: coralinhingray@hotmail.com, coraline-hingray@chu-nancy.fr (C. Hingray).

PNES divided into two groups on the basis of presence or absence of trauma antecedents.

2. Methods

2.1. Patients

Between October 2009 and November 2010, consecutive patients with video/EEG-confirmed PNES (with and without associated epilepsy) were enrolled in the Neurology Department of the University Hospital of Nancy, after providing us their written informed consent.

2.2. Trauma assessment

Trauma antecedents in childhood were sought using the Childhood Trauma Questionnaire (CTQ), a retrospective 28-item self-assessment validated in French [15]. The CTQ was developed to provide a brief, valid assessment of a broad range of negative experiences in childhood and adolescence (emotional neglect and abuse, physical neglect and abuse, and sexual abuse) with cutoff scores. To assess trauma antecedents in adulthood, we systematically reviewed traumatic events such as physical and sexual attacks, accident, bereavement, traumatic death, and a relative with an incurable disease. Presence or absence of trauma was used to classify patients into two groups: trauma group and no-trauma group.

2.3. Biographical factors

In a clinical interview, we systematically reviewed sociodemographic factors: sex, age, education level (normal secondary schooling to age 15 or 18), employment, and economic dependence. History of PNES included age at onset, duration, epileptic comorbidity, antiepileptic drugs taken, situational triggering factors (interpersonal conflict and anger in the context of punishment, prohibitions, daily restrictions, denial of a desired object, situations that require patience or waiting, etc.), and possible perpetuating factors such as "sick leave" elicited with specific questions.

2.4. Assessment of psychiatric comorbidity, alexithymia, and dissociation

Psychiatric comorbidity and history were investigated using a clinical and semistructured psychiatric interview [MINI-DSMIV-TR], depression scales (Montgomery-Åsberg Depression Rating Scale [MADRS]) [16] and anxiety scale (Hamilton Rating Scale for Anxiety [HAM-A]) [17].

Psychological features were studied with two scales. The Toronto Alexithymia Scale (TAS-20), a 20-item instrument, is the most commonly used measure of alexithymia [18,19]. Alexithymia is trouble identifying and describing emotions with a tendency to minimize emotional experience and focus attention externally. The Dissociative Experience Scale (DES) is a 28-item self-report inventory of dissociative phenomena experienced throughout life such as depersonalization/derealization, amnesia, and absorption/imaginative involvement [20,21].

2.5. Statistical analysis

Given the small sample size, we used nonparametric tests. Dichotomous categorical variables were compared using the bilateral Fisher exact test (FE). Quantitative variables were described through the median, and comparisons between groups were made with the nonparametric *U* test of Mann and Whitney (MW). Correlations between quantitative variables were explored with Spearman's rank correlation test. A *P* value <0.05 was considered significant (Statistica software).

3. Results

We screened 31 consecutive patients (age range: 18–47 years). Six patients were excluded as they were unable to complete all the questionnaires because of their low level of understanding. Of the 25 consecutive analyzed patients, 19 (76%) had at least one trauma antecedent and formed the "trauma" (T) group. Six patients (24%) had no trauma antecedent and formed the "no-trauma" (NT) group.

3.1. Description of trauma in the trauma group

In the T group, 5 patients had not suffered maltreatment during childhood or adolescence (as evaluated with the CTQ), but reported traumatic events preceding PNES, such as being told of a relative's incurable disease or witnessing a violent death. During childhood, 12 patients (63%) were subjected to sexual abuse and 10 (53%) to emotional abuse. During adulthood, 9 patients (47%) were subjected to physical assault. All the patients reported several types of trauma (median number = 3).

3.2. Biographical factors

3.2.1. Sociodemographics

There were no significant differences in age, gender, educational level, employment, or economic dependence between the two groups. However, there was a higher percentage of men in the NT group (50% vs 11%, *P* = 0.069). Educational level also was lower in the NT group, only one patient completing schooling to age 15 (17% vs 58%, *P* = 0.16) and none to age 18 (Table 1).

3.2.2. History of psychogenic nonepileptic seizures

The two groups did not differ in age at onset of PNES, epileptic comorbidity, antiepileptic drug treatment, or duration of disease. "Frustration" as a factor triggering PNES (100% vs 21%, *P* = 0.001) and subsequent "sick leave" as a result of PNES (100% vs 0%, *P* < 0.001) were significantly more frequent in the NT group (Table 1).

3.3. Psychiatric comorbidity

No patient in the NT group had a history of psychiatric comorbidity or current psychiatric disorder. One had a histrionic personality disorder. All patients in the T group had at least one psychiatric comorbid condition or a psychiatric history. Nine patients in the T group (47%) had a mood disorder and the same proportion had a

Table 1
Biographic factors in the trauma and no-trauma groups.

| Biographic factor | Trauma group (<i>n</i> = 19) | No-trauma group (<i>n</i> = 6) | <i>P</i> | Statistical analysis |
|---|----------------------------------|------------------------------------|--------------|-------------------------|
| Median age | 28 | 35 | 0.824 | MW |
| Female gender | 17 (89%) | 3 (50%) | 0.070 | FE |
| Schooling to at least age 15 | 11 (58%) | 1 (17%) | 0.160 | FE |
| Schooling to at least age 18 | 6 (32%) | 0 (0%) | 0.278 | FE |
| Usually employed | 8 (42%) | 5 (83%) | 0.160 | FE |
| Economic dependence | 11 (58%) | 2 (33%) | 0.378 | FE |
| Median age at onset of PNES | 18.5 | 17.9 | 0.924 | MW |
| Median duration of disease | 5 years | 1.5 years | 0.633 | MW |
| Epilepsy | 8 (42%) | 2 (33%) | 1 | FE |
| Antiepileptic drugs | 13 (68%) | 3 (50%) | 0.630 | FE |
| "Sick leave" because of PNES (if applicable) | 0 (0%) | 5 (100%) | 0.001 | FE |
| Frustration as trigger of PNES | 4 (21%) | 6 (100%) | 0.001 | FE |

MW, Mann-Whitney *U* test; FE, Fisher's exact test.

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