EMDR treatment for dissociative seizures

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**Dissociative seizures**

- Result of dysregulated physiological arousal
- Triggered by traumatic event, series of events or an unhelpful start in life
- Effective treatment changes physiological functioning, through body-focused therapy
  - 73% patients’ symptoms significantly reduce or stop completely with this treatment
Formulation is key

- Understanding of what causes physiological changes and how to recover from them
- Confidence to self-manage it and explain it to others
- Reduction of feelings of vulnerability

= Independence from symptoms
PTSD – A Event, B Intrusion symptoms, C Avoidance, D Cognitive change, E Arousal

- dissociative reactions including complete loss of awareness of present surroundings
- Marked physiological reactions to internal or external cues that symbolize / resemble the trauma. Feelings of detachment from others.

With dissociative symptoms: Depersonalisation (observer of self) or derealisation (unreal world)
Other Specified Dissociative Disorder 300.15 (F44.89)

**Dissociative trance:** Loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli... may be accompanied by minor stereotyped behaviours (e.g. finger movements) of which the individual is unaware and/or he or she cannot control, as well as transient paralysis of loss of consciousness. Not normal for collective cultural or religious practice.
Conversion Disorder (Functional Neurological)
- Rarely seen in mental health services
- Abnormal thoughts, feelings and behaviours in response to these symptoms
- It is not appropriate to give an individual a mental disorder diagnosis solely because a medical cause cannot be demonstrated.
- But “is possible to demonstrate definitely that symptoms are not consistent with medical pathophysiology.”
  - Somatic symptom disorder = most symptoms cannot be demonstrated to be inconsistent with pathophysiology (e.g. pain and fatigue)
- Differences in medical care across cultures affect the presentation, recognition, and management of these somatic presentations.
Neurological symptoms found to be incompatible with neurological pathophysiology

If the symptoms are fully explained within the particular cultural context and do not result in clinically significant distress or disability, then the diagnosis of conversion disorder is not made.

Common co-morbidity is dissociative disorder
ICD-10

* Diseases of the nervous system VI
  * Shock – traumatic T79.4

* Mental and behavioural disorders V: Dissociative (conversion) disorders F44
  * Dissociative convulsions F44.5:
    * mimic epileptic seizures very closely in terms of movements, but tongue-biting, bruising due to falling, and incontinence of urine are rare, and consciousness is maintained or replaced by a state of stupor or trance.

* Somatoform disorders F45
  * Somatoform autonomic dysfunction F45.3:
    * Does not indicate a physical disorder of the organ concerned
    * palpitations, sweating, flushing, tremor, and expression of fear and distress about the possibility of a physical disorder

* Other neurotic disorders F48.8
  * Psychogenic syncope
ICD-10 Somatoform disorders

The main feature is repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis*. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient.

*Absence of an explanation is in no way reassuring
Understanding these conditions from a neurophysiological perspective

- Autonomic nervous system dysregulation
  - limbic system hyper responsive
  - reduced hippocampal volumes
- Neuroendocrine stress axis dysregulation or sensitisation
- Sleep disruption, lowered immune response
- Treatment that stabilises the central nervous system works: - constructive rest, resilience building, yoga, mindfulness, meditation, some medication and processing trauma
Limbic system ‘survival centre’

Acute (or chronic in PTSD) response to extreme stress / trauma / threat

Sets hypothalamic pituitary adrenal axis in motion, releasing hormones to tell the body to prepare for defensive action

SURVIVAL OPTION 1: Limbic system activates sympathetic branch of autonomic nervous system: a state of heightened arousal, preparing the body for *fight* or *flight*

SURVIVAL OPTION 2: If fight or flight perceived as not possible, limbic system activates parasympathetic branch of autonomic nervous system causing a drop in arousal / the body to *freeze*
The effects of trauma on the body

- Hyper-arousal (heart rate, breathing)
- Hypo-arousal (shut off, numb)
- Sleep disruption (nightmares, poor sleep)
- Flashbacks
- Mind and body reliving event as if it were now
Resilience = **successful** application of body’s adaptive response to stress or ‘allostasis’

- However allostasis can be exaggerated or fail to cease and mechanisms which were protective become pathological = ‘allostatic load’ can result in physiological or psychological damage

- Allostatic mechanisms
  - Neuroendocrine system (Hypothalamo-pituitary-adrenal axis)
  - Immune system
  - Central (autonomic) nervous system
Hyper and Hypo arousal

- Hyper-arousal:
  - Extreme hyper vigilance (mind and body)
  - Heart racing
  - Muscle tension
  - Convulsions/ twitches/ jerks of limbs and trunk

- Hypo-arousal:
  - Feeling slowed down
  - Feeling like they are drifting from reality
  - Cognitive slowing
  - Emotional and physical numbness
Model of Physiological Arousal

Too much physiological arousal:
- anxiety, panic, easily startled, dissociative

Narrowed window of physiological resilience

Too little physiological arousal:
- feeling switched off, numb, unresponsive, dissociative
Animal and war models for stress vulnerability and resilience

- Early life stress
- Chronic unpredictable stress / loss of predictability
- Chronic social defeat stress
- Learned helplessness

- WWII gastric ulcer rate higher in suburbs (less regularity) and ulcer rates dropped to normal after a few months of bombing
EMDR for MUS

- Trauma has strong relationship with somatisation (esp. persistent pain)
- Fibromyalgia = 57% have PTSD symptoms
- Dissociative seizures = 62% have PTSD symptoms
- High rates of childhood trauma, therefore unresolved trauma = symptoms?
- Therefore trauma treatment is needed
Why EMDR?

* Fast and permanent changes to physiology
* Stabilisation and processing
  * Grounding and resilience-building
  * Changing physiological responses quickly
  * Moving the mind and physiology, temporarily
  * Moving the mind and physiology, permanently: turning down the Bunsen burner
What is trauma focussed therapy?

Trauma = dysregulation

Body

Learning bodily signs, progressive muscular relaxation, safe place exercise, practical problem solving

Mind

Grounding, understanding of the symptoms and their management, having a plan

STABILISATION and then PROCESSING

Resolving problematic meaning, unhelpful self-referential beliefs and reversing bodily responses
EMDR and Trauma-focussed CBT more effective over time (4 months) than non-trauma focussed talking therapy.

Why is all talking therapy not trauma informed?
  * Read Jaqui Dillon or John Read www.jacquidillon.org
Healing trauma

1. Traumatised people should not be re-traumatised or abused further by the NHS

2. POVERTY MATTERS


Trauma treatment


* Herman J (1997) *Trauma and Recovery.* Basic Books