Psychogenic non-epileptic seizures (PNES), also known as non-epileptic attack disorder (NEAD), are events that often mimic an epileptic seizure, but without the characteristic electrical discharges associated with epilepsy. That is, they look like a seizure but do not show any electrical activity on an EEG.

PNES are triggered by psychological mechanisms, and frequently occur in conversion disorder. It is estimated that 20% of seizure patients seen at specialist epilepsy clinics have PNES.

**Diagnosis**

The differential diagnosis of PNES firstly involves ruling out epilepsy as the cause of the seizure episodes, along with other organic causes of non-epileptic seizures, such as syncope, migraine, vertigo, and stroke, for example. However, between 5-20% of patients with PNES also have epilepsy. Frontal lobe seizures can be mistaken for PNES, though these tend to have shorter duration, stereotyped patterns of movements and occurrence during sleep.

Next, factitious disorder (simulating seizures intentionally for psychological reasons) and malingering (simulating seizures intentionally for secondary gain such as compensation or avoidance of criminal punishment) are excluded. Finally other psychiatric conditions that may superficially resemble seizures are eliminated, including panic disorder, schizophrenia, and depersonalization disorder.

The most conclusive test to distinguish epilepsy from PNES is long term video-EEG monitoring, with the aim of capturing one or two episodes on both videotape and EEG simultaneously (some clinicians may use suggestion to attempt to trigger an episode).

**Terminology**

The use of older terms including pseudo seizures and hysterical seizures is discouraged.[5] While a non-epileptic seizure may resemble an epileptic seizure, pseudo can also connote "false, fraudulent, or pretending to be something that it is not." Psychogenic non-epileptic seizures are not false, fraudulent, or produced under any sort of pretense.

The condition may also be referred to as non-epileptic attack disorder, functional seizures, or psychogenic non-epileptic seizures.
Distinguishing features

Some features are more or less likely to suggest PNES but they are not conclusive and should be considered within the broader clinical picture. Features that are common in PNES but rarer in epilepsy include: biting the tip of the tongue, prolonged seizures (easiest factor to distinguish), seizures having a gradual onset, a fluctuating course of disease severity, the eyes being closed during a seizure, and side to side head movements. Features that are uncommon in PNES include automatisms (automatic complex movements during the seizure), severe tongue biting, biting the inside of the mouth, and incontinence.

Risk factors

Most PNES patients (75%) are women, with onset in the late teens to early twenties being typical. PNES patients often have a history of multiple vague, unexplained medical problems and may have a psychiatric condition such as major depressive disorder or an anxiety disorder or bipolar disorder. A number of researchers have identified abnormal personality traits or personality disorders in patients with PNES such as borderline personality. The presence of these personality disorders, often related to a trauma in childhood, has led to researchers postulating that PNES may be an expression of repressed psychological harm in response to trauma such as child abuse. Over-emphasizing these theories to patients may lead to false memory syndrome so they should be introduced delicately. Other traumatic experiences such as bullying in adulthood, learning disabilities, sexual abuse or adverse family dynamics may also be important predisposing or maintaining factors.

Treatment

Psychotherapy is the most frequently used treatment, which might include cognitive behavioral therapy, insight-orientated therapy, and/or group work. It is important, however to find a therapist who has an understanding of the condition. There is some tentative evidence supporting the selective serotonin reuptake inhibitor antidepressants.

Explaining a diagnosis of PNES can be difficult and needs to be done in a sensitive and open manner. Often the person has been being treated for epilepsy for a number of years. A negative diagnosis experience may cause frustration and could cause a person to reject any further attempts at treatment. It may help when explaining the diagnosis to the person and their caregivers to include:

- Reasons for concluding they do not have epilepsy
- What they do have (describe dissociation)
- Emphasize they are not suspected of "putting on" the attacks
- They are not "mad"
- The positive outcomes that they no longer need to use anti epileptic drugs (AED)
- May improve after correct diagnosis
- Caution that the withdrawal of AED’s should be gradual
- A description of appropriate psychological treatment and a referral
References


LaFrance WC, Jr; Reuber, M; Goldstein, LH (March 2013). "Management of psychogenic nonepileptic seizures.". Epilepsia. 54 Suppl 1: 53–67. PMID 23458467.


Although every effort has been made to ensure accurate and up to date information is provided. Epilepsy Queensland Inc and its advisors cannot accept any liability in relation to the information provided. It is strongly recommended that you discuss any information with your doctor or other organization.