Psychodynamics and Psychotherapy of Pseudoseizures

Dalma Kalogjera-Sackellares PhD

"Lion Goddess" fighting a giant. The goddess is possibly Keto, mother of the Graiae, who are walking away to the left (missing).

Hellenistic relief, 164–156 BCE
Antikensammlung, Staatliche Museen zu Berlin

Frontispiece photo credit: Bildarchiv Preussicher, Kulturbesitz/Art Resource, NY

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Foreword

This is a book about the psychodynamics and treatment of patients with psychogenic pseudoseizures. It is the product of years of intensive work dedicated to understanding the psychological features and the underlying psychodynamic mechanisms and to the formulation and testing of an effective therapeutic approach. To understand the psychodynamics of patients with psychogenic pseudoseizures, it was necessary to evaluate a very large number of patients with a well-established diagnosis of pseudoseizures, with a variety of diagnostic tools, and to follow a subset of these patients over extended periods of time.

A famous German writer, Georg Christian Lichtenberg, is said to have questioned why it never struck researchers that discoveries could be made not only with a magnifying glass, but also, perhaps with a diminishing lens (cited in Ferenczi, 1927). In her investigations into the problem of pseudoseizures, the author used a "magnifying glass" to examine the details in each case. However, to an even larger extent, she relied on capturing the large constellations generated by groupings of clinical features presented by the patient population as a whole ("diminishing lens" approach).

There has been a trend in pseudoseizure scholarship to search for a single mechanism which is of decisive importance. The strength of the author's approach is to demonstrate family resemblance among different presentations of the syndrome (the importance of not missing the forest for the trees).

It was necessary to evaluate a large number of patients because of the wide range of psychological complaints,

signs and symptoms found in these patients. At first glance, it appears that one is dealing with a common symptom (pseudoseizures) resulting from a large number of different psychological disorders. However, through a careful study, using all of the diagnostic tools at her disposal, the author was able to identify common themes and patterns which permitted her to formulate a few well-defined syndromes, thus substantially reducing the great complexity of the clinical material.

It is also important to point out that this work is based upon evaluation of patients with a well-established diagnosis of pseudoseizures. Establishing a confident diagnosis of pseudoseizures in a large number of patients, in a reasonable period of time, is a task that could not have been achieved until some time around 1980. Up until that time, neurologists had to rely primarily upon the history provided by the patient, members of the family, or close friends. Observing a pseudoseizure first-hand was a chance occurrence which was, unfortunately, all too rare. However, with the institution of long-term EEG-video monitoring as a diagnostic tool, it became possible to record representative examples of a patient's seizures (and/or pseudoseizures). This tool provided the opportunity to analyze videotaped recordings to study the fine details of the patient's behavior during the event and to analyze the electroencephalogram (EEG) for extended periods, including the crucial period just before, during, and just after each event. This new technology taught the neurologist an important lesson in humility: even the best clinician can misdiagnose a pseudoseizure as an epileptic seizure or mistake an epileptic seizure for a psychogenic pseudoseizure. Armed with this new diagnostic tool, a number of clinical investigators began to investigate this troublesome problem, the psychogenic pseudoseizure. Now that we could identify the pseudoseizure with some degree of confidence, we could provide our psychological colleagues with a well-defined group of patients, based on an accurate diagnosis of the presenting symptom.

The author's psychological insights about pseudoseizures are derived from a very diverse range of methods (psychotherapy, neuropsychological testing, and personality testing). The diagnostic evaluations were performed personally by the author, using a diagnostic protocol established in the Neuropsychology Program at the University of Michigan. Each tool helped to describe a different aspect of this multifaceted disorder. One of the key contributions, from which she drew heavily, was extensive clinical histories obtained during interviews with the patients.

The author was thus confronted, from the beginning, with information as diverse as motor speed and grip, on the one hand, and Minnesota Multiphasic Personality Inventory profiles and psychodynamic themes emerging from the Rorschach on the other. Information emerging from extensive evaluations of this kind necessarily contains a great deal of richness. It resists strongly any attempt to reduce it rashly to a single parameter or a single issue. The author's approach was based on the decision to admit whatever was there and to understand as much of each individual component as was possible, thus letting each emerging issue speak for itself, as it were, without forcing spurious unity. This kind of approach requires that the clinician tolerate some degree of uncertainty which stems from different issues existing side-by-side, without an obvious connection. Some of the results of personality and neuropsychological testing have been published as original articles in peer-reviewed journals.

We might say that pseudoseizure syndromes are a large canvass disorder. This book helps to deal with some of the issues which make it so. A large canvass disorder requires that we accept whatever information has been obtained reliably and not exclude any, or attempt to translate one type of information into another. It is not one insight, as opposed to another, but one insight in connection with another.

In Dr. Kalogjera-Sackellares's investigations into the nature of pseudoseizures, insights and information derived from psychotherapy hold a special place. A subset of pseudoseizure patients was followed in psychotherapy over extended periods of time (months, and in some cases, years). While it is customary to think of therapy as treatment, it is really, in an equal measure, an investigation (true to its historical origins). The capacity to follow patients over time provided her with a temporal perspective that proved to be of great value in understanding this disorder. Without this longitudinal perspective, it would not have been possible to gain an appreciation for the chronicity of the disorder and the frequently changing and evolving clinical features.

This book will prove useful to psychologists, psychiatrists, neurologists, and other professionals who are engaged in the diagnosis and treatment of patients with psychogenic pseudoseizures. In the text, sophisticated psychological concepts and technical terms are explained with a clarity of language that renders it accessible to neurologists with little psychological training. For psychologists and other readers who may not be familiar with some of the diagnostic issues involved in distinguishing epileptic from pseudoseizures and the diagnostic tools used for that purpose by neurologists, I will provide a brief summary.

Psychogenic pseudoseizures are transient paroxysmal events during which the patient experiences symptoms and exhibits behaviors similar to those symptoms and behaviors that occur in epileptic seizures. Pseudoseizures can mimic many different types of epileptic seizures, most commonly complex partial or tonic-clonic seizures. Unlike epileptic seizures, pseudoseizures are not associated with organized paroxysmal rhythmic discharges in the EEG. The epileptic seizure occurs because massive numbers of neurons in the cerebral cortex and connecting structures fire off in rhythmic synchronized patterns for periods of a few seconds (in the

Select contributions from psychoanalytic theory

Complicated mourning and the nature of loss

In 1917, Freud published an essay entitled "Mourning and Melancholia". In this influential essay, he made important conceptual distinctions between two different types of response to loss and outlined their psychodynamic patterns.

Mourning refers to *grief*, whereas melancholia is closest to our current concept of *complicated mourning*. In this work, I take the view that complicated mourning plays a key role in a certain subset of traumatic conditions. Much of the psychological difficulty, often very disruptive and lasting, we encounter in post-traumatic states occurs as a consequence of mechanisms which occur in complicated mourning.

Both grief and complicated mourning occur in response to a loss, typically the loss of a loved one. Both involve such features as "profoundly painful dejection, abrogation of interest in the outside world, loss of the capacity to love, inhibition of all activity" (p. 153). In short, the world becomes impoverished. Complicated mourning is aggravated by the additional burden of loss of self-esteem, often very marked. This reaction is not a part of normal mourning.

The work of mourning

The process of responding to the loss of a loved one can be very intense and very laborious. One of Freud's important contributions to our understanding of depressive and post-traumatic states is his view that the person does not simply give up lost love objects as a matter of course. The process of adaptation to the loss involves an intense struggle between two strongly opposed psychological aims. On the one hand, there is an urge to cling emotionally to the lost person as

long as possible, and, on the other, the disengagement from him or her.

The process of psychological distancing is described by Freud (p. 154) in the following terms:

> The task is now carried through bit by bit, under great expense of time and cathectic energy, while all the time the existence of the lost object is continued in the mind. Each single one of the memories and hopes which bound the libido to the object is brought up and hyper-cathected, and the detachment of the libido from it accomplished. Why this process of carrying out the behest of reality bit by bit, which is in a nature of a compromise, should be so extraordinarily painful is not at all easy to explain in terms of mental economics.

In more personal terms, the work of mourning is described by one of Freud's followers, the psychoanalytic author and clinician Theodor Reik (Reik, 1940, p. 10 of Preface) ironically, in response to the loss of Freud himself to whom Reik was strongly attached:

> I know, now that the impression has passed, that we are called again to the labor of sorrow, that unseen, prolonged process of separation in which we take leave of our dear departed. It is work against great odds, for so many objects, places and circumstances remind us of the time he was still with us. How can we accomplish this work which takes place so heart-breakingly in the midst of memory? Yet this silent process of the psyche is necessary, for our energy must be dedicated to the demands of the day.

These are two complex statements which summarize a number of distinct insights about the nature of mourning. To begin with, we are dealing with the process in which the individual does not wish to take part, a struggle not of his own choosing with which he finds himself obliged to cope. No one mourns because they really want to. On the contrary, mourning is a process of compulsory adjustment.

Why resistance to mourning? Resistance stems from the very nature of affective attachments. According to Freud, affective attachments are build on a foundation of psychic energy—it takes energy to build them, and, conversely, it takes perhaps even more energy to take them apart. Emotional connections are, in a manner of speaking, stabilized energy. Because the psyche is essentially conservative which means not eager to change patterns of emotional investment, attachments are not dissolved automatically in response to a loss. They do not simply fade away. They are taken apart, at a psychological cost to the person.

Freud made an additional observation about the process of mourning. He remarked that the memories and hopes which bound us affectively to the lost person are revived, in fact, they return to the awareness with added emotional charge. This effectively means that, in order to forget, one must first remember vividly, i.e., one must experience, often in a forceful way, that which one is seeking to put behind psychologically. Thus, in order to mourn successfully, one must be willing to take a risk of experiencing something in an unwelcome way.

One might say that mourning is a form of emotional revival which has more to do with re-experiencing than with remembering. Clearly, this would imply a state of considerable emotional vulnerability. The vulnerability is exacerbated by the fact that the emotional revival of memories in mourning is not a predictable process. Neither the patient nor the therapist can anticipate which memories will be brought forth and with what emotional force.

Remembering in mourning is rarely a serene reminiscence; and it rarely unfolds in a smooth sequence. Rather, it can have a fitful, spasmodic course (more of a smooth muscle contraction than smooth sailing).

It is a process which is not really under the patient's conscious control; one does not start out with an agenda. Once begun, the emotional revival of memories can acquire a momentum of its own with fits and starts. The unpredictable nature of this process is something the patient senses—somehow—and fears. Therefore, he or she needs support from the therapist to ensure that mourning is not stopped prematurely, i.e. before a sense of relief and closure have been achieved.

Our discussion of mourning should be qualified by pointing out that not all people mourn with the same intensity and that a stormy course is not inevitable. The nature, as well as depth of attachment, vary from individual to individual, and so does the manner in which they respond to disruption and losses in their lives. However, in clinical settings, it is by no means uncommon to encounter the more intense forms of mourning described above. For that reason, it would be helpful if the therapist were able to recognize that the disruptive and unpredictable nature of the process of mourning is a part of a well-known pattern, as opposed to being an aberration from some ideal smooth way of coping with loss.

The process of mourning entails not only active working through of revived affect and memories, but also the opposing psychological force which drives the person to return to the business of living. This is a natural, self-protective mechanism to ensure that the person will be mobilized out of their grief, back into the external world to respond again to life's demands, opportunities and other people. Thus, the natural outcome of normal mourning is expected to be favorable, and the process itself self-limited.

Complicated mourning

In his work with patients who had suffered a loss, Freud observed that some forms of mourning were accompanied by a marked loss of self-esteem, whereas others were not. He

maintained that the loss of self-esteem was absent in normal grief. However, in other, more complicated forms of mourning, the loss of self-esteem was particularly striking. It manifested itself in highly critical statements that patients made about themselves. These self-critical statements were not only very poignant and elaborate, but they appeared quite unrealistic.

After struggling to account for this paradoxical situation, Freud eventually concluded that the exaggerated self-criticism was in fact directed towards the person whom the patient had lost (through death or disappointment). It was a part of the emotional response towards another person. One is dealing then with an ambivalent attachment, that is to say one in which a strong attachment is complicated by hostile feelings which the patient cannot accept or deal with in some simple way.

Freud concluded from the self-hate he observed in patients with complicated mourning, that they acted as if the anger and hostility they felt toward the love object had now been absorbed (through a process called identification) into oneself and then turned against oneself.

This mechanism of internalizing experience permits the person who is grieving to hold onto the lost love object psychologically, if they cannot hold onto it in reality. It is a substitute for the lost "real thing" and its function is to ensure that "the existence of the lost object is continued in the mind" (Freud, 1917, p. 154). Thus, "in spite of the conflict with the loved person the love relation need not be given up." (p. 160).

This defensive mechanism is intended to spare the person the impact of loss. However, this relief comes at a psychological cost to the bereaved person, namely the internalized hostility is now turned against the self. It is easy to see how this process would lay foundation for the development of

depressive states and depressive vulnerability is indeed one of the major consequences of identifications of this type.

Another feature of the process of identification is that it is unconscious—it is not someone's chosen conscious strategy for overcoming a loss. It is, in a sense, a protective settlement which has been negotiated out of awareness to save time and spare the person psychological pain. Thus, the advantage of unconscious defenses is that they operate automatically and protect without expending much energy which is typically required for thinking things through very carefully and considering only the best options.

The automatic nature of the defense mechanisms can be compared to the way in which spinal and cerebellar mechanisms adjust posture after someone trips. If we needed to reason through every postural adjustment, we could not really walk.

On the other hand, because these protective psychic mechanisms are not conscious, they are not easily detected or controlled, and they cannot be simply turned on and off at will. As important as they are in shielding the person from the full impact of an experience, they are only partial solutions.

The loss of someone who was ambivalently loved is not the only loss which can trigger complicated mourning. Freud noted that it could also occur in response to losing something more abstract with which the person is strongly involved emotionally, such as, for example, one's country, or liberty, or an ideal (Freud, 1917, p. 153).

This observation has important implications. It permits us to expand the definition of loss to include a variety of life's circumstances, particularly traumatic circumstances, because trauma and loss share a good deal of common ground

"Neurologists diagnose patients with psychogenic non-epileptic seizures (pseudoseizures), but generally do not understand the underlying psychopathology or treatment rationale. *Psychodynamics and Psychotherapy of Pseudoseizures* is a major contribution to the field. This remarkable treatise provides a theoretical framework to explain clinical presentations of patients with pseudoseizures and support therapeutic interventions."

Steven C. Schachter MD
Professor of Neurology, Harvard Medical School

"… enjoyable and informative to read … a useful guide to people who treat patients with not only pseudoseizures but other pseudo-neurological disorders."

Michael R. Trimble MD FRCP FRCPsych
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"Excellent ... an important work ... should be in every epilepsy library."

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