Commentary

# Seizures that are not epileptic

Patients with psychogenic nonepileptic seizures move in the borderland between the fields of neurology and psychiatry. Following current practice, the diagnosis is made by a neurologist, who then hands over the treatment of the patient to a psychologist or psychiatrist. There are several potential difficulties with this process. Many patients experience their seizures as physical and may have problems in understanding and accepting the diagnosis (1). Furthermore, there may be a long period between diagnosis and an offer of treatment. Many patients with no obvious psychiatric problems do not receive an offer of treatment at all, because they are not perceived to be sufficiently ill. There may also be a lack of knowledge about the condition among the psychiatric treatment apparatus.

The patient group is heterogeneous, and it can be challenging to tailor the treatment to the individual. Those who have not undergone major traumas or had serious psychiatric illness can become seizure-free after having had the diagnosis conveyed to them in an empathic manner (2). However, most will require treatment. The man in this case report was thoroughly examined, and he received treatment from several different agencies. His seizures did not improve until he was diagnosed and treated for a bipolar disorder. Comorbid psychiatric conditions are very common in this patient group, particularly in the form of depression, anxiety and personality disorders. In a recently published study, 10 % of the patients had bipolar disorder (3). In the treatment of patients with psychogenic nonepileptic seizures it is important to identify and treat comorbid conditions of this type. Untreated depression and anxiety are associated with persistent attacks (4).

It is currently believed that both psychological factors and biological vulnerability play a part in the development of the condition (2). In about 20 % of the patients there are pathological findings with cerebral MRI, EEG or neuropsychological testing (5). In recent years several neurobiological markers have been identified in these patients, and a biopsychosocial understanding of the condition is in the process of being elaborated (2).

The aetiology is most often complex and may be made up of different factors, such as previous experience of traumas, difficult life events, dysfunctional family relationships, psychiatric comorbidity and organic brain dysfunction. An insufficiently holistic patient care pathway may make the diagnosis itself becoming an additional burden for the patient (1). It is not difficult for us to align ourselves with the authors who advocate for closer collaboration between neurologists and psychologists in general, and around this patient group in particular.

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