Working with clients with epilepsy - by Paul Peace C.Psychol, HPD

At some point most therapists will be approached by a client who has experienced, or is currently experiencing, epileptic seizures. It seems fair to say there is quite a lot of fear and confusion around this subject. Hopefully I can bring some clarity, based on my awareness of the current state of knowledge.

What is epilepsy?

NHS http://www.nhs.uk/Conditions/Epilepsy/Pages/Introduction.aspx 07.07.09 (the tense has been edited as this is from a self-help file):

'Epilepsy is not a single medical condition in itself. It is a symptom of a range of other conditions that cause somebody to have repeated fits, known as seizures.

Epilepsy is a relatively widespread condition, affecting around 456,000 people in the UK. The condition usually begins during childhood but it can start at any age. Around one in every 280 children is affected by epilepsy.'

The cells in our brain, known as neurons, communicate with each other by using electrical impulses. During a seizure these electrical impulses are disrupted, which can cause both the brain and the body to behave strangely.

The severity of the seizures can differ from person to person. Some people will just experience a trance-like state for a few seconds or minutes, whereas others will lose consciousness and have convulsions (uncontrollable shaking of the body).

Epilepsy is not normally life-threatening, although physical injury can occur as a result of seizures. In rare cases, epilepsy can cause sudden, unexplained death. This is known as sudden unexpected death in epilepsy (SUDEP), which kills 500 people in the UK every year.'

'Symptoms

The main symptoms of epilepsy are repeated seizures.

Doctors who treat epilepsy classify seizures by how much of the brain is affected. There are:

- partial seizures - where only a small part of the brain is affected, and
- generalised seizures - where most or all of the brain is affected.

Partial seizures

There are two types of partial seizure:

- simple partial seizure - this is a seizure where the individual remains conscious, and
- complex partial seizure - this is a seizure where the individual's consciousness is affected, they lose their sense of awareness and have no memory of the event.

Symptoms of a simple partial seizure include:

- experiencing changes in the way things look, smell, feel, taste or sound,
- experiencing an intense feeling of déjà vu (a feeling that these events have happened before),
- experiencing a sudden intense emotion, such as fear or joy,
- the muscles in their arms, legs and face may become stiff, and
- they may experience twitching on one side of their body.

The symptoms of a complex partial seizure are normally characterised by apparently strange and random bodily behaviour, such as:

- smacking their lips,
- rubbing their hands,
- making random noises,
- moving their arms around, and
- chewing, or swallowing.

During a complex partial seizure, they will not be able to respond to anyone else, and they will have no memory of the event.

Complex partial seizures are quite common, accounting for two in 10 of all seizures experienced by people living with epilepsy.

Generalised seizures

There are six main types of generalised seizure, which are described below.

Absences:
This type of seizure mainly affects children. They cause the child to lose awareness of their surroundings for five to 20 seconds. The child will seem to just stare vacantly into space, although some children will flutter their eyes or smack their lips. They can occur several times a day. Though they are not dangerous, they may affect the child's performance at school.

Myoclonic jerks:
These types of seizures cause their arms, legs or upper body to jerk or twitch - much like if they have received an electric shock. They often only last for a fraction of a second, and the individual should remain conscious during this time.

Clonic seizure:
This causes the same sort of twitching as myoclonic jerks, except the symptoms will last longer, normally up to two minutes. Loss of consciousness may occur.

Atonic seizure:
This causes all of their muscles to suddenly relax, so there is a chance they will fall to the ground.

Tonic seizure:
Unlike an atonic seizure, this causes all of the muscles to suddenly become stiff and the individual can then lose balance and fall over.

Tonic-clonic seizure:
This type of seizure has two stages. The individual's body will become stiff and then their arms and legs will begin twitching. They will lose consciousness and some people will wet themselves. The seizure normally lasts between one and three minutes. This is the most common type of seizure, accounting for 60% of all seizures experienced by people living with epilepsy.

Tonic-clonic seizures are typically what people are referring to when the use the term 'epileptic fit'.

People can experience any of the above types of seizure, but usually the pattern of somebody's symptoms remains the same. This pattern is known as an epilepsy syndrome.

Auras

People who have epilepsy often get a distinctive feeling or warning sign that a seizure is on its way. These warning signs are known as auras.

Auras differ from person to person, but some common auras include:

- noticing a strange smell or taste,
- having a feeling of déjà vu,
- feeling that the outside world has suddenly become unreal or dreamlike,
- experiencing a sense of fear or anxiety, and
- their body suddenly feels strange.

While it is normally not possible to prevent the seizure from occurring, the individual can act on the warning signs by telling people that they think a seizure is on the way. Also, they should get into a safe place and position so they do not damage their body during the seizure.'

'Epilepsy triggers

Many people with epilepsy find that certain circumstances or substances can trigger a seizure. These triggers include:

- stress,
- lack of sleep,
- alcohol, particularly if a large amount is drunk in a short time (binge drinking),
- illegal drugs (cocaine, amphetamines, ecstasy and any opiate-based drug, such as heroin, methadone or codeine),
- health conditions that cause a high temperature (fever), and
- flashing lights - this is actually quite a rare trigger, affecting only 5% of people with epilepsy.

Some women may find that they are more prone to having seizures just before the start of their period. This is because the hormones released by the body during the time can change the chemical composition of the brain, making seizures more likely.

Also the changes in mood many women experience before their period - premenstrual tension (PMT) - can make them feel stressed and anxious, which again increases the chance of a seizure.'

<u>Is it safe to work with clients with epilepsy?</u>

Some training schools and hypnotherapists suggest that one should not use hypnotherapy with epileptic clients. An internet search will also show the pervasiveness of this view. When proponents of this view are asked to explain further it normally seems to centre around fear, assumptions about professional codes, or reducing risk to the therapist of legal action and complaints (which is a therapist's right, of course), rather than a genuine care for the client.

So should we avoid working with people with epilepsy? A search of academic and clinical databases (ASSIA, PsycInfo, PubMed, Cochrane, and Medline) reveals little. Anecdotally, I have heard of a number of hypnotherapists working with people with epilepsy without triggering a seizure. I too have worked without any problems, as has my very experienced supervisor and mentor, for many years. A clinical psychologist (neuropsychology) student of mine stated in a private email, 'I have had a discussion with one of our Consultant Neurophysiologists about hypnosis and the potential to bring about seizure and he does not think that this is an issue any more than it would be in any type of therapy for epilepsy patients. His take on the matter is that it is more likely that a patient will experience seizure by coincidence during hypnosis, rather than

as a result of trance and he would not have any concerns about hypnosis being used with epilepsy patients.'

Epilepsy is a condition that is often made worse by stress. Hypnotherapy is generally relaxing. Even when dealing with difficult and sensitive issues clients do not normally appear stressed - normally just emotional (though they can sometimes be stressed by interventions, of course). If an intervention or abreaction were to be very stressful it can be contained using a 'safe place' (e.g. anchor, or asking them to 'file this away like a book on a library shelf', or using dissociation e.g. viewing themselves or the problem on a screen 'out there').

Some say we should refer to a medical practitioner and obtain a letter to be sure that it is safe to proceed. Do GPs (*generally*) know enough about hypnotherapy and it's effects to be able to advise on this? The GPs answer is likely to be based on anecdote and whim and seems rather pointless. It is, of course, worth asking the client whether they are in the care of an expert on epilepsy, such as a neurologist, who can advise. However, logically, they must also understand hypnosis to be able to pass judgement on the connection between hypnosis and epilepsy and come to a professional decision. We can always take the opportunity to meet with them and explain what we do. It is nice to reach out to other professions to spread understanding of what we do as well as useful for marketing ourselves.

A personal view is that therapists too often 'pass the buck' to an authority to absolve themselves from responsibility if something goes wrong. This is 'safe' for the therapist but not necessarily 'caring and professional'. Another personal view is that it would be a shame to deprive those with epilepsy - a significant number of people - from something as natural and normally relaxing as hypnotherapy based on fear and therapist self-protection (though I do respect alternative views, of course). And of course, all clients experience natural trance (though not necessarily *interventions*), every day.

What do the professional bodies say?

I contacted a sample of professional bodies (the GHR, NCP, and NCH) in July 2009:

GHR - William Broom - Membership Secretary

Although there are those both within orthodox medicine and outside of it who suggest that hypnotherapy (or rather any relaxation techniques and procedures that hypnotherapy may include) could well trigger a seizure, the GHR has not seen any compelling evidence to support this view. Whilst we continue to advise that some manifestations of epilepsy could contra-indicate hypnotherapy in certain instances (and this would rather depend upon the specific information afforded by the client or perhaps contained within any medical notes that might be available to the therapist), as a general rule we confirm that it is perfectly acceptable to proceed with therapy provided that the therapist concerned is entirely comfortable in doing so. (N.B. We feel that the therapist should retain the right to refuse therapy to an epileptic client if that factor should cause the therapist discomfort. There would seem little point in carrying out therapy when the therapist's concerns over the client's epileptic condition are likely to mitigate against a successful outcome of the presented problems.)

As further precautionary advice, we suggest that the therapist should, as far as is practicable, ensure that there are no objects in the (epileptic) client's vicinity that could cause injury in the event that a seizure should occur which might result in the client collapsing to the floor and succumbing to muscle spasms and other involuntary movements.

We naturally remain prepared to review our position in the light of subsequent research evidence in the matter.

NCP - David Doohan - Membership Secretary

In reference to your letter regarding epilepsy, please find the following which are MY OWN PERSONAL OBSERVATIONS after very many years of practice.

Q. Should a hypnotherapist work with a client with epilepsy?
A. It has been my experience that, providing a hypnotherapist has enough (suggested minimum three years) experience, working with a broad range of problems then they are likely to be successful working with an epileptic client.

Q. Does it matter if it is medically well managed.
A. Yes, this is most important regardless of the severity of the condition. A client who does not have a medically well managed condition is not going to be a successful client as they are not going to work well with anyone for anything, as evidenced by their ill managed epilepsy.

Q. Should the clients GP be involved.
A. This is not always necessary (bear in mind client confidentiality) but it may be best for THE CLIENT to check with their GP before any treatment commences.

In the past I have worked very successfully with clients suffering with this condition and, provided that you are mindful of the condition and prepared for a POSSIBLE seizure, then you can treat them in the same way as any client.

This is the information I give to Members of the NCP when they seek my advice regarding this condition in clients.

I will also advise any therapist (NCP Member or not) who does not feel comfortable with the possible outcome of a seizure, to refuse treatment and suggest an alternative therapist with more experience who will treat them. This is the same advice I give to any Member who has doubts concerning any treatment; remember, the clients well being ALWAYS comes first.........

NCH - Trevor Silvester - Director of Ethics

'I agree with the points made in your article, and that, if a therapist feels comfortable working within those constraints, and the client has given an informed consent, then work is perfectly possible.'

'…The point should also be made that, based on the information given to me, hypnosis isn't harmful to epileptics per se, it may just trigger a seizure. With the informed consent of the client, and the presence of a person competent to deal with such an occurrence, then I could see a case for working with epileptic clients.'

Some sensible precautions if you do decide to proceed

- Be sure your professional body permits you to work with epilepsy. The GHR, NCP and NCH currently do, provided of course the therapist is competent.
- Be sure your insurance covers working with clients with epilepsy (a senior underwriter at Towergate Insurance Services informed me they do 08.07.09).
- Ask the client if they are in the care of an epilepsy specialist who also understands hypnotherapy. Refer to them if so and obtain a letter. If the client wishes to appeal to the authority of a GP we should respect this, despite any misgivings we may have about their ability to form judgements on something they generally know nothing about.
- Avoid promising zero risk and explain to clients the current state of knowledge so that they proceed with informed consent.
- Explain, on a written contract, that you cannot guarantee that your work together would be free of seizures and ask the client to sign this to express their informed consent.
- Advise clients that they are always able to bring themselves out of trance at will and they can communicate throughout. They should let you know if the telltale 'aura' appears.
- Make sure the client has space around them from the outset in case they have a seizure so that they do not bring themselves to physical harm (e.g. against sharp consulting room furniture).
- Avoid inductions and suggestions that involve seizure triggers (e.g. flashing lights such as photography and strobe lighting - not normal hypnotherapy fodder, of course!). Ask the client what their particular triggers are so you can avoid them.

- It is possible to induce seizures deliberately in people with epilepsy using hypnosis. This has been done for research or diagnostic purposes and involves direct suggestion to experience a seizure or taking clients back to actual memories of seizures (e.g. Bryant, 1995; McGonigal, *et.al.*, 2002). This should therefore be avoided.
- Ask the client what *they* would like you to do if they have a seizure.

If a seizure occurs

- Help is not normally needed.
- Stay calm and respect the client's wishes. Stay with them for reassurance where possible.
- Make a note of the time the seizure started.
- Call 999 only if the seizure lasts longer than five minutes, or if the client has a series of seizures without regaining consciousness.
- Seek medical help if it is the client's first ever seizure or if they have injured themselves.
- Move any objects that may cause injury and move the client if this is not possible.
- The client's head should be cushioned if they move to the floor.
- To aid breathing, loosen any tight clothing around the client's neck, such as a tie.
- When the convulsions cease, note the time and…
- Turn the client onto their side and remain with them or ask someone else to until they have recovered, and…
- Make transport arrangements, preferably with an accompanying adult.
- Without inducing further trance, the client can be asked if they would like to do some basic healthy breathing exercises, to think of a favourite place, or they might utilise a relaxation anchor.
- Do not restrain the client in any way.

According to the NHS website (http://www.nhs.uk/Conditions/Epilepsy/Pages/Recovery.aspx 03.08.09), 'it is impossible for somebody to swallow their own tongue during a seizure. While somebody having a seizure may bite their tongue, these bites are normally not serious, and will heal in a few days. There are no recorded cases of anyone biting their tongue off during a seizure. Attempting to stop somebody biting their tongue, by placing your hand or an object in their mouth, could be dangerous both for you and them.'

Recording information about seizures

As a witness, the therapist will have important information about the seizure. This could be invaluable to the client's GP or neurologist, helping them with diagnosis and treatment. Of course, the person with epilepsy may not have been able to monitor themselves in this way during a seizure.

The NHS website advises the following information be collected (http://www.nhs.uk/Conditions/Epilepsy/Pages/Recovery.aspx 03.08.09):

- 'Where was the person? What were they doing?
- Did the person mention any unusual sensations, such as an odd smell or taste?
- Did you notice any mood change, such as excitement, anxiety or anger?
- What brought your attention to the seizure? […] body movements such as eyes rolling or head turning?
- Did the seizure occur without warning?
- Was there any loss of consciousness or altered awareness?
- Did the person's colour alter - for example pale, flushed or blue? If so, where - face, lips or hands?
- Did any parts of the body stiffen, jerk or twitch? If so, which parts were affected?
- Did the person's breathing alter?

- Did they perform any actions, like mumble, wander about or fumble with clothing?
- How long did the seizure last?
- Was the person incontinent (i.e. couldn't control their bladder or bowels)?
- Did they bite their tongue?
- How were they after the seizure?
- Did they need to sleep? If so, for how long?'

After a seizure

Allow space fro the client to recover and let them guide you as to how much conversation they wish to engage in. They may wish to sit somewhere for a while, or sleep. If suitable, provision of a couch would pose less of a challenge to our ethical boundaries than a bed. Assume the client will want to continue to work with you unless they say otherwise. It would seem sensible to avoid creating an atmosphere of apology (which unnecessarily and probably incorrectly implies therapist responsibility). Obtain feedback on what they think triggered the attack, and any preceding aura, and record and avoid this in future sessions. Perhaps you can continue your work together using non-trance techniques if they become fearful of trance. Tactfully and non-defensively remind the client that seizures can occur anywhere and there is no necessary connection between the trance and the seizure; though worrying, it is probably coincidence.

Therapy for epilepsy as a presenting issue

I am not aware of any significant research suggesting hypnotherapy is beneficial at *treating* epilepsy (quite a different concern, of course, than simply working on another issue with a client who experiences epilepsy). However, what we certainly *can* do is to 'work around' the presenting issue - something hypnotherapists are well used to. For example, epilepsy can be frightening and can reduce confidence. Confidence-building and managing fear and anxiety are therefore very helpful. Panic may also be triggered in certain situations. For example, the client may panic about being in a particular shop where they experienced a seizure in the past. Working with stress and healthy breathing are further possibilities. Another possibility is to give direct suggestion that they can comfortably accommodate, for example, flashing lights without experiencing problems. However, testing the outcome should only be by chance event rather than deliberate exposure to the trigger unless it is medically supervised (or it is something unavoidable and routinely present in the client's day to day life anyway). As always, guarantees should not be given.

By Paul Peace, with special thanks to those people who commented upon and improved earlier drafts: William Broom (GHR Secretary), David Doohan (NCP Membership Secretary), Trevor Silvester (NCH Director of Ethics), and Mary Llewellyn (my mentor and supervisor). Paul is a Chartered Psychologist, Hypnotherapist, Accredited Supervisor and Hypnotherapy Trainer. He may be contacted via his website: www.training-hypnotherapy.co.uk

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